

Infant Initials: _____

Daily Record

Date: _____

Please record your infants' activities starting this evening through tomorrow morning. Draw a line through the boxes or mark an X in the times during which the following behaviors occurred. Try to record to the nearest $\frac{1}{2}$ hour.

	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	
Asleep																				
Awake and quiet																				
Awake and active																				
Crying/fussy																				

Today, my baby ate:

Time	Type of Food/Liquid	Amt/Duration

Please record your infant's mood, behavior and health in the past week:

<p>My baby was active/alert: 1 2 3 4 5 Much less usual much more</p> <p>My baby was hungry: 1 2 3 4 5 Much less usual much more</p> <p>My baby was content: 1 2 3 4 5 Much less usual much more</p> <p>My baby was sleepy: 1 2 3 4 5 Much less usual much more</p> <p>My baby was fussy/cranky: 1 2 3 4 5 Much less usual much more</p> <p>My baby cried: 1 2 3 4 5 Much less usual much more</p>	<p>My baby had:</p> <p><input type="checkbox"/> vomiting <input type="checkbox"/> fever</p> <p>(temp: _____)</p> <p><input type="checkbox"/> ear pain/infection <input type="checkbox"/> rash</p> <p><input type="checkbox"/> runny nose <input type="checkbox"/> cough</p> <p><input type="checkbox"/> constipation <input type="checkbox"/> diarrhea</p> <p><input type="checkbox"/> other _____</p> <p>Doctor's visit?</p> <p>Diagnosis?</p> <p>Medication or treatment?</p>
<p>My baby did/was:</p> <p style="text-align: center;">for the first time this week.</p>	

Notes: Please note any changes in your infant's eating, sleeping, or diapers. Please also note any illnesses you may have or any medications that you are taking (such as return to oral contraceptives). Feel free to record anything else you would like.