NATIONWIDE CHILDREN'S

When your child needs a hospital, everything matters.℠

PATIENT IDENTIFICATION

Comprehensive Pediatric Feeding and Swallowing Program

Intake Form

Please take some time to complete this form to give us general information about your child's feeding history. Feel free to write any comments that you think may be helpful to us in evaluating your child.

Child's Name_____Birth date: _____Date Form Completed_____

Others living in the home, and relationship:

_____

_____

_____

_____

Names of other doctors outside of NCH involved with your child:

- ☐ Cardiology _____
- ☐ GI _____
- ☐ Nutrition _____
- ☐ ENT _____
- ☐ Psychology_____
- ☐ Pulmonary _____
- ☐ Allergy _____
- ☐ Neurology _____
- ☐ Other_____

I. Particular Needs

Cultural considerations:

Do you speak English? ☐ Yes ☐ No Do you need an interpreter? ☐ Yes ☐ No

Ethnic Background: _____

Are there any cultural or religious practices regarding food or affecting how we care for your child?

☐ Yes ☐ No

If so, describe: _____

II. Feeding Problems:

What **problems** is your child **now** having? (Check as many problems as your child has)

- ☐ Will not eat enough food by mouth
- ☐ Refuses to eat certain kinds of food (smooth, lumpy, crunchy, spicy) Describe: _____

☐ Seems to have problems taking liquids. Describe _____

_____

☐ Seems to have difficulty with solid foods. Describe: _____

_____

☐ Seems to have difficulty with temperature of food or liquids (too hot or too cold)

☐ Other: _____

When did you first notice feeding problems? _____

Does your child have any oral restrictions? _____

What do you think caused these feeding problems? _____

_____

What is your goal for the Feeding Evaluation Clinic Visit? _____

_____

_____

_____

_____

III. Medical History

Therapy Programs and School:

Does your child receive therapy?	How often?	Where?	For Feeding?
☐ Occupational Therapy	_____	_____	_____
☐ Physical Therapy	_____	_____	_____
☐ Speech Therapy	_____	_____	_____
☐ Other therapy	_____		

IV. Review of Issues

Type of feed	**Past**	**Present/Current**
☐ NG (nasogastric tube feeds)	☐	☐
☐ OG (oral gavage feeds)	☐	☐
☐ NJ (nasojejunal feeds)	☐	☐
☐ GT (gastrostomy tube feeds)	☐	☐
☐ TPN (total parental nutrition)	☐	☐
☐ JT (jejunal feeds)	☐	☐

On average, how many ounces does your child drink a day? _____ ounces

What liquids does your child now take?

☐ Milk _____ ounces per day

☐ Formula _____ ounces per day Which Formula? _____

How many meals/snacks does your child usually eat in a day? _____meals _____snacks

Food my child likes

Foods my child dislikes