NATIONWIDE CHILDREN'S

When your child needs a hospital, everything matters.℠

PATIENT IDENTIFICATION

Comprehensive Pediatric Feeding 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: _____ Sex ☐ M ☐ F

Telephone Numbers:

Home: _____ Work: _____ Cell: _____

Address:

Street _____ Apt.# _____

City: _____ State: _____ Zip Code: _____

Father's
Name:_____

Mother's
Name: _____

Children:

_____

_____

_____

_____

Others living in the home, and relationship:

_____

_____

_____

_____

Child is living with:

☐ Biological parents

☐ Adoptive parents
☐ Single parent father

☐ Foster parents

☐ Single parent mother
☐ Parent and Step-parent

Does child occasionally live in any other household?

☐ Yes
☐ No
☐ Other _____

Insurance Information:
Insurance Company Name: _____

Employee Name: _____

ID/Subscriber #_____

Group#: _____ Phone#: _____

Primary Doctor/Pediatrician:

Doctor's Name:_____ Phone: _____

Address: _____

City: _____State: _____ Zip Code: _____

Names of other doctors 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: _____

Are there any learning barriers for the parent/guardian or child? _____

Parent/Guardians:

- ☐ None
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Other_____

Child:

- ☐ None
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Other_____

Have there been any recent or ongoing stressors at home/with family that would impact your child's feeding issues? _____

_____

_____

Do you have enough resources for food? ☐ Yes ☐ No

Check all that you participate in: ☐ WIC ☐ Food stamps ☐ Other _____

Diagnosis:

What have you been told is your child's main problem or diagnosis? _____

_____

Who diagnosed this problem? _____

_____

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

Allergies:

Does your child have any allergies?

☐ Seasonal _____

☐ Food _____

☐ Medications _____

☐ Other _____

Does your child have problems with eczema? ☐ Yes ☐ No

Medications: Please list all medicines, over-the-counter products, and natural/herbal remedies your child takes.

Name of medicine	Dose	How often?	Name of medicine	Dose	How often?

Therapy Programs and School:

Does your child receive therapy? How often? Where?

- ☐ Occupational Therapy _____ _____
- ☐ Physical Therapy _____ _____
- ☐ Speech Therapy _____ _____
- ☐ Other therapy _____

Is feeding a focus of the therapy? _____ What is being worked on? _____

_____

_____

_____

_____

_____

Name of present school or program: _____ Grade: _____

Child attends ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri For ____ hours a day

Does this program work on feeding? ☐ Yes ☐ No

Is your child enrolled in a special class? ☐ Yes ☐ No
If yes, please describe: _____

Did your child repeat a grade? ☐ Yes ☐ No

Birth History:

Was your child born:

☐ Full Term ☐ Premature _____ # weeks

Weight at birth: _____

Were there any problems during pregnancy?

- ☐ Gestational diabetes
- ☐ Pre-eclampsia
- ☐ _____
- ☐ _____

Any problems during labor/delivery?

- ☐ Birth trauma
- ☐ Needed resuscitation

_____

_____

Was your child in NICU after birth? ☐ Yes ☐ No

If so, was your child on a ventilator? ☐ Yes ☐ No

How long?_____

Was your child fed by NG, OG, NJ, GT, Etc?

_____

List any problems that occurred before your child was discharged:

- _____
- _____

After birth, when was your child first discharged from the hospital? _____

Did your child go home nippling all or with a tube feeding?_____

Has your child ever had **surgery**?: ☐ Yes ☐ No Please list what was done, when, and where.

	Surgery	Date	Where?
1.			
2.			
3.			
4.			

Has your child ever been **hospitalized**?: ☐ Yes ☐ No Please list when and where:

	Reason	Date	Where?
1.			
2.			
3.			
4.			

Please list any **procedures** or **tests** within the past year: (UGI, Swallow Study, Ph Probe)

	Test	Date	Results
1.			
2.			
3.			
4.			
5.			
6.			

Does your child have any **medical conditions** not listed above?

IV. Review of Issues

A. Feeding History

Was your child:

☐ Breastfed When stopped _____

☐ Bottle-fed When stopped _____ Type of bottle _____ Nipple _____

Were there any **problems with breastfeeding**?

_____

_____

_____

_____

_____

Were there any **problems with bottle feeding**?

_____

_____

_____

_____

_____

Which **formulas** have been tried or were tried first? _____

When did you first introduce **solid foods**? _____

Has your child ever needed:

Type of feed	When started	When stopped
☐ NG (nasogastric tube feeds)	_____	_____
☐ OG (oral gavage feeds)	_____	_____
☐ NJ (nasojejunal feeds)	_____	_____
☐ GT (gastrostomy tube feeds)	_____	_____
☐ TPN (total parental nutrition)	_____	_____
☐ JT (jejunal feeds)	_____	_____

B. Current feeding skills:

- ☐ Bottle
- ☐ Sippy cup
- ☐ Feeds himself/herself
- ☐ Finger foods
- ☐ Regular cup
- ☐ Straw
- ☐ Spoons/utensils
- ☐ Non-oral

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

How many bottles a day does your child drink? _____

How many cups a day does your child drink? _____

What liquids does your child now take?

- ☐ Milk _____ ounces per day
- ☐ Formula_____ ounces per day Which Formula? _____
- ☐ Juice _____ ounces per day
- ☐ Water_____ ounces per day

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

Food my child likes

Foods my child dislikes

How long does it usually take for your child to eat a meal? ☐ 30 minutes or less ☐ 30-60 minutes ☐ ≥ 60 minutes

Tube Feeding Questions **(If not applicable go to C. Feeding Behaviors):**

What method of feedings does your child use now?

☐ Nasogastric (NG) ☐ Nasojejunal (NJ)
☐ Gastrostomy (g-tube) ☐ Jejunostomy (j-tube) ☐ Other _____

Are your child's feedings:

☐ **Continuous** - How many hours_____ (ml.) (cc) per hour _____
Start time_____ Stop time _____

☐ **Bolus** - How much _____(ml. of formula per feeding)
How often _____ (number of feedings per day)

☐ **Combination** _____

What are the **times** your child is fed? _____

What **type of formula** is your child receiving? _____

Does your child have any of the following associated with tube feeding?

☐ nausea ☐ vomiting ☐ diarrhea
☐ cramping ☐ constipation ☐ other symptoms _____

Does your child receive water in addition to formula?

☐ Yes, How much? _____ How often? _____
☐ No

Who supplies the formula for tube feeding?

☐ WIC ☐ Medicaid ☐ BCMH ☐ Homecare company ☐ Family ☐ Care facility

C. Feeding Behaviors

Behavior noted during feeding (check all that apply)

☐ Gets tired easily ☐ Poor appetite ☐ Refuses bites offered
☐ Vomits during feeding ☐ Vomits after feeding ☐ Chews but does not swallow
☐ Cries during feeding ☐ Leaves the table ☐ Loses lots of food out front of mouth
☐ Tantrums ☐ Purposeful spit ☐ Eating time is stressful for child/parent
☐ Other _____ ☐ Holds food in his/her mouth

Please describe other concerns about your child's behavior or emotional condition: _____

_____

_____

_____

D. Oral Issues

Does your child allow you to brush his or her teeth? ☐ Yes ☐ No

Does he or she tolerate this well? _____

Does your child have a history of: (check all that apply)

☐ Gagging ☐ Drooling ☐ Long-term NPO

E. Pharyngeal Issues

☐ Choking ☐ Gurgly vocal quality

F. Respiratory Issues

☐ Gets colds that last too long ☐ Wheezing ☐ Aspiraton ☐ Pneumonia ☐ Hoarse voice

G. GI Issues

☐ Crying after feedings ☐ Constipation ☐ Inability to gain weight

☐ Nausea ☐ Ruminating ☐ Vomiting after feedings ☐ Chronic diarrhea

V. Feeding Environment:

Who usually feeds your child? _____

What works best when trying to feed your child? _____

_____

Do you feed your child at the **same time** every day? ☐ Yes ☐ No

If yes, please list feeding times. _____

If no, please list reasons _____

Where do you feed your child most often?

☐ Infant seat ☐ Booster seat ☐ Lap ☐ Highchair ☐ Wheelchair ☐ Other

How is your child **positioned** for feeding? ☐ Sitting in chair ☐ Lying Down ☐ On lap

Which **meal** does your child do best with? ☐ Breakfast ☐ Lunch ☐ Dinner

Do you feed your child when the rest of the family is eating? ☐ Yes ☐ No If no, when is your child fed in relation to family meals? _____

During **eating times**, are there other **activities** going on in the area where your child is eating? (check all that apply)

☐ TV is on ☐ Music is on ☐ Other activities _____

In **what room** do you feed your child?

☐ Kitchen ☐ Living room ☐ Dining room ☐ Baby's room ☐ Family room ☐ Other

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Thank you for completing this survey!

Comprehensive Pediatric Feeding Program

Patient Name:_____

Date of visit:_____

Family History

Please tell us about any diseases or conditions that run in the child's family. Please place a check in the column of the family member affected by the conditions listed. Only people who are related to the child by blood (not marriage) should be included.

	Father	Mother	Mat. GF	Mat. GM	Pat. GF	Pat GM	Sibling	Other	Comment
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐
Birth defects (congenital anomalies)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cerebral Palsy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Chronic Cough	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cong. Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Developmental Delay	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Failure to thrive	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disease /Syndromes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
High BP	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hx poor reaction to sedation/anesthesia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mood Swings/Bipolar	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐
Panic Attack	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychosis/Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reflux Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Renal Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizure Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐	☐	☐	☐	☐
Speech problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other diseases or conditions	☐	☐	☐	☐	☐	☐	☐	☐	☐