Patient's Name: ___________________
Date of Birth: ___________________

Mt. Washington Pediatric Hospital, Inc.
CENTER FOR NUTRITIONAL REHABILITATION
New Patient Information Form Infant/Toddler

1708 West Rogers Avenue ♦ Baltimore, Maryland 21209-4596
*(410) 367-2222 ♦ **FAX:** (410)578-5245*

PLEASE OBTAIN A COPY OF YOUR CHILD'S GROWTH CHART FROM YOUR PRIMARY CARE PHYSICIAN AND ATTACH TO THIS FORM. RETURN ALL FORMS TO THE ABOVE ADDRESS

Today's Date: ____________

Name of person completing the form ______________________Relationship to child: __________
Do you have custody of child: Yes No If not, who does: ______________________________
Patient Name: ____
Date of Birth: _____________Age:_________ Current Weight: __________Ht: __________
Patient Ethnicity: (Please note: for informational purposes and is optional) **PLEASE CIRCLE**

0-Caucasian 3-Asian
1-African American 4-Other_____________
2-Hispanic

Preferred Language: ____
Address: ____
Telephone: Home: __________________Cell: ________________Work: ________________
E-mail Address: ______________________________
Parent's name: ____
Referring Physician: ___________________________ Phone: ______________________
Medical Diagnosis:____

What are your feeding or nutrition concerns: ____

____

Does your child have any food allergies?___ Yes ______ No

If yes, list the specific food allergies:____

Does your child have any food intolerance? ____Yes ____No

FEEDING HISTORY:

Breast fed: Yes No

If yes, how long: _________ and if yes please circle one: **Pumped** or **Nursed**

Describe any difficulties with breast feeding/nursing: ___________________________

Patient's Name: ___________________
Date of Birth: ___________________

What infant formulas were used: ____

Describe any difficulties: ____

At what age were rice cereal and baby foods introduced: _______________________________

Described any difficulties: ____

At what age were table foods introduced: ____

Describe any difficulties: ____

Are there foods do you avoid giving to your child: (please list)____

Is there evidence of pain during swallowing? _____ Yes ______ No

If yes, explain____

Has your child ever had any problem with the following?

Choking?	______ Yes	______ No
Gagging?	______ Yes	______ No
Coughing with solids/liquids	_____ Yes	______ No

If yes,

a. At what age did the problem start?___________
b. At what age did the problem stop?___________

Does your child have vomiting ? If so, when does vomiting occur?

During feeding?	______ Yes	______ No
After feeding?	______ Yes	______ No
Unrelated to feeding?	______ Yes	______ No
When upset?	______ Yes	______ No

How often does vomiting occur?
______ Times per day______ Times per week_____ Times per month____ Occasionally

How often does your child have a bowel movement?

______ Times per day______ Times per week_____ Times per month____ Occasionally

Are stools usually

a. Watery c. Pasty
b. Formed d. Runny
c.

Has your child ever had a problem with ongoing constipation? _____Yes ____No

If yes, explain____

Patient's Name: ____________________
Date of Birth: ____________________

Does your child receive tube feedings (NG or G-tube)? _______Yes _____No

What is the schedule (include volume of each feeding and water flushes)____________

____

What rate is your child's tube-feed? ____

What formula is used for the tube feed?_______________________________________

How is the formula prepared (if not ready to feed) ______________________________

Has there been any problems tolerating the current tube feed? _______Yes_______No

Describe if problems are occurring _______________________________________

What consistencies does your child eat (circle all that apply): smooth, soft, crunchy, chewy (meat), mixed/lumpy.

What problem(s) does your child have with feeding? (Check all that apply)

____________ Eats too fast	______ Eats too little	______ Messy eater
____________ Eats too slow	______ Eats too much	______ Plays with food
____________ Does not chew	______ Pushes food away	______ Leaves table
____________ Eats non-food items	______ Sneaks food	_______ Picky eater
____________ Spits food out	______ Refuses to open mouth	______Drools
____________ Throws/drops food	______ Takes food from others	_____ Ruminates
____________Cries or tantrums	______Refuses to swallow food	____ Vomits
___________ Coughs	______Turns away from spoon	____ Gags

Other ____

What feeding techniques do you use with your child to get him/her to eat?

______ Coax	______ Distract with toys	______ Limit foods
______ Threaten	______ Change meal schedule	______ Spank
______ Offer reward	______ Mini-meals	______ Force feed
______ Ignore	______ Praise	______ Use television
______ Send to room/time out		______ Change foods offered

Other ____

Where do you feed your child? Check all that apply:

______ Lap
______ Infant seat
______ High chair (regular____________adapted____________)
______ Booster seat
______ Table/chair
______ Modified chair (e.g., wheelchair, rifton chair, etc)
______ Couch
Other____

Patient's Name: ____________________
Date of Birth: ____________________

Does your child self-feed? ______ Yes ______ No
Using hands? ______ Yes ______ No
Using utensils? ______ Yes ______ No

Is it hard for you to tell if your child is hungry? ______ Yes ______ No

What is your child's daily feeding schedule? ____

____

Does your child eat or have access to food between meals? ______ Yes ______No

Does your child's food intake vary much from
Meal to meal? ______ Yes ______ No
Day to day? ______ Yes ______ No

Is your child likely to eat more at one meal than other meals? ______ Yes ______ No

If so, which meal and why?____

Does your child eat better for one caregiver or the other? ______ Yes ______ No

If yes, please specify the individual:____

How long does a typical feeding/meal take?
_______Less than 15 minutes
______ 15-30 minutes
______ 30-60 minutes
______ More than 60 minutes

Does your child drool during feeding? ______ Yes ______ No

Can your child bite off pieces of food? ______ Yes ______ No

Does your child pocket food in his/her cheeks? ______ Yes ______ No

Does your child use any special utensils or cups? ______ Yes ______ No

Does your child drink from a bottle, sippy cup, open cup, straw? (circle all that apply)

Has your child received any other feeding therapy? ______ Yes ______ No

If yes, explain (when, where, who, how long) _____________________________________

____

EATING STYLE:

How many meals eaten outside the home/ week: ______ Where: ___________________________

Favorite foods: ____

Favorite drinks: ____

Number of meals a day: 1 2 3 4 5 6 more?______

Patient's Name: ____________________
Date of Birth: ____________________

Eats at the table with family: Always Never Sometimes

Eats in front of television: Always Never Sometimes

How many hours per day does your child watch TV: ________________________

Is your child picky about certain foods: Yes No

If yes, what foods and brands are accepted:

____

Is your child on a special diet: Yes No

If yes, which one(s): ____

What time of day is your child most hungry: **PLEASE CIRCLE**

0-Morning
1-Afternoon
2-Evening
3-Late Night

How many times a day does your child say she or he is hungry: **0 – 1 – 2 – 3 – 4 – 5 - More**

Does your child eat before going to bed: Yes No, what is eaten:_____________________

Does your child wake up hungry at night? Yes No, what is eaten: _____________________

How many ounces will your child drink at one time:______________________________________

Does your child drink from a sippy cup, with a straw or from cup?___________________________

What does your child usually choose to drink: **PLEASE CIRCLE ALL THAT APPLY**

0-Soda how much per day (ounces or cups):_______________________
1-Juice how much per day (ounces or cups):_______________________
2-Water how much per day (ounces or cups):_______________________
3-Milk how much per day (ounces or cups):_______________________
4-Other:______________________

<u>PAST MEDICAL HISTORY:</u>

Birth History:

Weight:_________Length:________Full Term: **Yes** **No** Premature: **Yes** **No**

If premature, at what week was child born: _______________

Please describe

Problems during pregnancy: Yes No _______________________________

Problems during delivery: Yes No _______________________________

Problems in the first month: Yes No _______________________________

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Please list any medical tests for feeding: (i.e. swallow study/upper GI/allergy testing) and note results of each____

____

Has your child ever been hospitalized: Yes No, please list ages and for what_______________

____

Has your child ever had surgery: Yes No, please list ages and for what __________

____

Has your child had any accidents: Yes No, please list ages and for what__________________

____

Has your child's hearing been evaluated? ______ Yes ______ No

When? ____

What were results? ____

DEVELOPMENTAL HISTORY: AT WHAT AGE DID YOUR CHILD:

Sit Up: ______
Walk: ______
First Word: ______
Toilet Train: ______

IMMUNIZATIONS AND ALLERGIES:

Are Immunizations up to date? Yes No

Allergy to Food: No Yes, please list: ____

Allergy to Medicine: No Yes, please list: ____

Allergy to Latex: No Yes

MEDICATIONS: Please list all medications within the last 3 months (include vitamins, health food remedies, etc.)____

____

FAMILY HISTORY:

Who lives in the home with your child? ____

Who is involved in your child's care? ____

Biological Parents:

Mother: Age: _____ Ht: _______Current Wt: _______

Father: Age: _____ Ht: _______Current Wt: _______

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Siblings:	Age	Male/Female
Full – Half – Step	_______	_ M F
Full – Half – Step	_______	M F
Full – Half – Step	_______	M F
Full – Half – Step	_______	M F
Full – Half – Step	_______	M F
Full – Half – Step	_______	M F

Circle if there is a family history of: (note: includes extended family- grandparents, aunts, uncles, cousins…)

Diabetes	Thyroid Problems	Obesity	Weight loss surgery
Peptic Ulcer	Reflux	Cancer	Eating disorders
Gallbladder	Liver disease	ADHD	Seizure
Pancreatitis	Constipation	Anxiety	Depression
Arthritis	Hypertension	Mental Retardation	Learning problems
Stroke	Heart disease	Personality disorder	Infertility
Kidney disease	Schizophrenia	Low Blood Pressure	Allergies, Food
Eczema	Cystic Fibrosis	Celiac Disease	Gastric Ulcers
Eating Disorder	Feeding Disorder	Irritable Bowel Syndrome	
Sickle Cell Trait or Disease		Thalassemia Trait or Disease	

Other ________________

SOCIAL HISTORY:

Caregiver marital status: **PLEASE CIRCLE**

- Married
- Sustained relationship (not married)
- Divorced
- Separated
- Single
- Widowed

Does your child go to day care: Yes (schedule: __________________) No, Sitter: Yes No

What grade is your child in: ______ What school does your child attend _______ ____________

How is your child's school performance: Poor Fair Average Excellent

Does your child have either an IEP: Yes No or 504 plan: Yes No

If yes, please detail:____

What is the quality of your child's relations with other kids: Poor Fair Average Excellent

Is your child happy: Yes No, please explain: ___________________________________

Is your child receiving OT, PT or Speech services? (Circle all that apply)

Number of times per week ____

Which agency provides the service? ____ Infants and Toddlers ___School ___Private

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Does your child understand commands? ______ Yes ______ No

How does you child communicate?

Verbal	______ Yes	______ No
Non-verbal	______ Yes	______ No
Gestural	______ Yes	______ No
Electronic device	______ Yes	______ No

Does your child communicate food preferences? ______ Yes ______ No

Does your child sleep through the night? ______ Yes ______ No

If not, why?____

Does your child have difficulty with separation? ______ Yes ______ No

Describe: ____

Do you have any concerns about your child's development or behavior? Yes ______ No

If yes, explain.____

Mother's highest level of education: **PLEASE CIRCLE**

High School
GED
Some College
College Degree
Graduate Degree

Mother's Occupation: ____________________ and number of hours worked/week: ____________

Father's highest level of education: **PLEASE CIRCLE**

High School
GED
Some College
College Degree
Graduate Degree

Father's Occupation:_____________________ and number of hours worked/week: ____________

Primary caregiver's work schedule: **CIRCLE ALL THAT APPLY**

Weekends
Weekdays
Days
Nights

Any significant changes in the family in the past 6 months: ________________________________

____

Patient's Name: ____________________
Date of Birth: ____________________

REVIEW OF SYSTEMS: Does your child have any of these symptoms:

			Comments
Allergy	Yes	No	________________________________
Bleeding Tendency	Yes	No	________________________________
Headaches	Yes	No	________________________________
Morning Headaches	Yes	No	________________________________
Trouble breathing	Yes	No	________________________________
Shortness of Breath	Yes	No	________________________________
Heavy Breathing	Yes	No	________________________________
Asthma	Yes	No	________________________________
Snoring	Yes	No	Sleep study: ____________________
Snores Loudly	Yes	No	________________________________
Mouth open during the day	Yes	No	________________________________
Heartburn	Yes	No	________________________________
Abdominal Pain	Yes	No	________________________________
Constipation	Yes	No	________________________________
Diarrhea	Yes	No	________________________________
Bedwetting/urinary problems	Yes	No	________________________________
Joint problems	Yes	No	________________________________
Tired in the morning	Yes	No	________________________________
Sleepy in school	Yes	No	________________________________
Easily distracted	Yes	No	________________________________
Difficulty organizing	Yes	No	________________________________
Interrupts conversations	Yes	No	________________________________
Wears glasses	Yes	No	________________________________
Trouble following directions	Yes	No	________________________________
Gagging	Yes	No	________________________________
Vomiting	Yes	No	________________________________
Frequent ear infections	Yes	No	________________________________

Has your child ever been treated for the following conditions:

			Comments:
ADHD	Yes	No	__________________________________
ODD	Yes	No	__________________________________
Anxiety	Yes	No	__________________________________
Depression	Yes	No	__________________________________
Mental Health Conditions	Yes	No	please describe____________________
Legal issues	Yes	No	___________________________________

What does your child do for physical activity? (For example plays at playground, dances etc.)
____
____

How much time each day does your child spend doing physical activities?___________________

Patient's Name: ___________________
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FOOD INTAKE LOG Fill out three days of food records, one sheet for each day. Under the column "Amount Consumed", do not use words like "pieces", "bites" or "sips". Instead use teaspoons, tablespoons, cups, or ounces. Under "Description", include the brand name of the food if it is a pre-made/packaged item.

Date & Day of Week:________________ Was child ill on this day? Y/N Vitamin/Mineral supplements taken: ________________________________G-Tube feedings – if applicable (name formula, feeding schedule, volume of each feeding, and water flushes):

____

____

Formula Recipe – if applicable (*example*: 6 scoops Enfamil Lipil powder + 10 ounces water):

____

Day's intake considered: □ Typical for Child □ More than Usual □ Less than Usual

____

DAY 1 **Time**	**Place food was consumed** (home, school, restaurant, etc)	**Food, Beverages** (Meals and Snacks)		**Amount Consumed**
		Food/Beverage Item	Description (include Brand name of food)	
Example 8 am	home	cereal	Cheerios	2 TBSP
		milk	2%	1 oz

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DAY 2 **Time**	**Place food was consumed** (home, school, restaurant, etc)	**Food, Beverages** (Meals and Snacks)		**Amount Consumed**
		Food/Beverage Item	Description (include Brand name of food)	

Patient's Name: ____________________
Date of Birth: ____________________

DAY 3 **Time**	**Place food was consumed** (home, school, restaurant, etc)	**Food, Beverages** (Meals and Snacks)		**Amount Consumed**
		Food/Beverage Item	Description (include Brand name of food)	

Patient's Name: ___________________
Date of Birth: ___________________

Please return your completed form to MWPH.

Mail to:

Mt. Washington Pediatric Hospital
Attn: Brooke Spund
1708 West Rogers Ave
Baltimore, MD 21209

Or Fax to us: 410-578-2654

Or use our secure email system – call Brooke at 410-578-5250 for the instructions to email this form using our secure messaging system.

If you chose to email this form to Mt. Washington Pediatric Hospital using unencrypted email, please sign below that you understand your child's personal and health information may be at risk if sent using an unsecured email system.
Include this consent with your form

____ _____________
Signature, parent/guardian Date