Patient's Name: _____
Date of Birth: _____

Mt. Washington Pediatric Hospital, Inc.

Feeding Clinic

New Patient Information Form

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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
1-African American
2-Hispanic
3-Asian
4-Other_____

Preferred Language: _____
Address: _____
Telephone: Home: _____Cell: _____Work: _____
E-mail Address: _____
Parent's name: _____
Referring Physician: _____ Phone: _____
Medical Diagnosis:_____

What are your feeding 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: _____

What infant formulas were used: _____

Patient's Name: _____
Date of Birth: _____

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: _____

What foods do you avoid giving to your child: _____

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?_____

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
b. Formed
c. Runny
d. Pasty
e. Formed

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 NG or G-tube feeding? _____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
_____ Turns away from spoon	_____ Gags	_____ Coughs

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)
_____ Stand/roam
_____ Floor
_____ 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

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: _____

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: _____

PAST MEDICAL HISTORY:

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 _____

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

_____

Patient's Name: _____
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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: _____

Siblings: Age Male/Female

Patient's Name: _____
Date of Birth: _____

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
Irritable Bowel Syndrome		Eating Disorder	Feeding Disorder
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
Does your child understand commands? _____ Yes _____ No

Patient's Name: _____
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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: _____
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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	_____

Thank you for taking the time to complete this questionnaire and for returning it to us in the self addressed stamped envelope.