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Last Name, First Name

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Mt. Washington Pediatric Hospital

CENTER FOR NUTRITIONAL REHABILITATION

New Patient Information Form School Age/ Adolescent

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 and 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: _____
E-mail Address: _____
Parent's name: _____ Work Telephone: _____
Referring Physician: _____ Phone: _____
What are your feeding or nutrition concerns: _____

BIRTH HISTORY:

Weight:_____Length:_____Full Term: **Yes** **No** Premature: **Yes** **No**

Which hospital?_____

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 _____

FEEDING HISTORY:

Breast fed: Yes No

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

What infant formulas were used: _____

Describe any difficulties: _____

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

Describe any difficulties: _____

Are there foods do you avoid giving to your child: please

list_____

Is there a history of feeding disorders: Yes No If yes, what kind: _____

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
b. Formed
c. Pasty
d. Runny

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

If yes, explain_____

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

If so, please detail the schedule below (include volume of each feeding and water flushes, rate, formula and how prepared if not ready to feed)_____

_____

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

Describe if problems are occurring _____

Does your child avoid any food consistencies? ___No ___Yes (If Yes, circle any that apply): smooth, soft, crunchy, chewy (meat), mixed/lumpy.

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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)
_____ Couch
Other_____

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?_____

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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

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

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

Has your child received any feeding therapy? _____ Yes _____ No

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

_____

EATING STYLE:

Does your child eat large meals: Yes No

Likes to nibble: Yes No

Skips meal: Yes No (if yes, which meal or meals, please circle):

Breakfast Lunch Dinner

Who grocery shops: **PLEASE CIRCLE ALL THAT APPLY**

0-Mother 1-Father
2-Both Parents 3-Grandparent
4-Child 5-Child and Parent
6-Child and Grandparent

Who prepares the meals: **PLEASE CIRCLE**

0-Mother 1-Father
2-Both Parents 3-Grandparent
4-Child 5-Child and Parent
6-Child and Grandparent

Number of fast food meals/week: _____ Which restaurant(s): _____

How many meals eaten outside the home/ week: _____ Where: _____

Does the child eat school breakfast? YES or NO School lunch? YES or NO

Favorite foods: _____

Favorite drinks: _____

Eats at the table with family: Always Never Sometimes

Eats in front of television: Always Never Sometimes

Does not eat much but has tendency to gain weight: Yes No

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Is your child particular about certain foods: Yes No

If yes, to which ones: _____

Have you previously tried any special diets: Yes No

If yes, which one(s): _____

Is your child on a special diet now: Yes No

If yes, which one(s): _____

Does family eat between meals: Yes No

What is eaten for snacks frequently (at least once a week): **PLEASE CIRCLE**

0-Cookies/Cakes	3-Sandwiches	6-Yogurt
1- Fresh Fruit (whole fruit,not juice)	4-Granola	7-Nuts
2-Chips	5-Cereal	8-Candy

_____

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

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

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

Does the child eat before going to bed: 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: _____

Is food hidden or eaten in secret by family members: Yes No Who:_____

Is there a history of eating disorders in the family: Yes No

If yes, please explain: _____

If there is a weight problem, have any contributed to your child's weight problems:

CIRCLE ALL THAT APPLY

0-Boredom	7-Eating Out
1-Stress	8-Snacking
2-Anger	9-Holidays
3-Happiness	10-No Activity
4-Sadness	11-Genetics
5-Food as Reward	12-Lack of Planning
6-Portions	13-Smell/Sight of Food

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PAST MEDICAL HISTORY:

What childhood illnesses have your child been treated for: _____

Has your child ever been hospitalized: Yes No, please list: _____

Has your child ever had surgery: Yes No, please list: _____

Has your child had any accidents: Yes No, please list: _____

Has your child had any special medical treatments for a medical condition: Yes No

If yes, please list: _____

ALLERGIES:

Allergy to Food: Yes No, please list: _____

Allergy to Medicine: Yes No, please list: _____

Allergy to Latex: Yes No

Immunizations up to date? Yes No

FAMILY HISTORY:

Biological Parents:

Mother: Age: _____ Ht: _____Current Wt: _____ Most you've weighed:_____

Father: Age: _____ Ht: _____Current Wt: _____ Most you've weighed:_____

Siblings:	Age	Ht.	Wt.	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	Reflux	ADHD	Depression
Peptic Ulcer	Liver Disease	Anxiety	Learning Problems
Gallbladder	Constipation	Mental Retardation	Other:_____
Pancreatitis	Hypertension	Personality Disorder	Polycystic Ovarian
Arthritis	Heart Disease	Schizophrenia	Syndrome
Stroke	Kidney disease	Weight loss surgery	
Infertility	Obesity	Eating Disorders	
Thyroid Problems	Cancer	Seizure	

SOCIAL HISTORY:

Caregiver marital status: PLEASE CIRCLE

0-Married 3-Single
1-Divorced 4-Widowed
2-Separated

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Who lives at home with your child: CIRCLE ALL THAT APPLY
0-Mother 1-Father 2-Sibling(s) 3-Grandparent(s) 4- Extended Family

Does your child go to day care: Yes No, Sitter: Yes No

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

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

What school and grade is your child in: _____

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:_____

Hours of television/night:_____Computer/night:_____Video games/night: _____

If your child plays video games, what kind: _____

How does your child spend free time? Please explain:_____

Child's energy level: Low Average High

Physical activity at home: _____ Parents involved: Yes No

Physical Education at school: Yes No, How often: _____

Hours of after-school organized sports a week: _____

Does anyone smoke in the home or around the child? Yes No

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

0-High School
1-GED
2-Some College
3-College Degree
4-Graduate Degree

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

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

0-High School
1-GED
2-Some College
3-College Degree
4-Graduate Degree

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

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

0-Weekends
1-Weekdays
2-Days
3-Nights

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

DEVELOPMENTAL HISTORY: AT WHAT AGE DID YOUR CHILD

0-Sit Up: _____
1-Walk: _____
2-First Word: _____
3-Toilet Train: _____

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

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

			Comments
Allergy	Yes	No	_____
Bleeding Tendency	Yes	No	_____
Recurrent 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	_____
Any other complaints of pain	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	_____
Irregular period	Yes	No	N/A_____

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Has your child ever been treated for the following conditions:

ADHD	Yes	No	_____
ODD	Yes	No	_____
Anxiety	Yes	No	_____
Depression	Yes	No	_____
Mental Health Conditions	Yes	No	please describe:_____
Behavior issues	Yes	No	please describe:_____

Does your child currently see a mental health professional? (school counselor, social worker, psychologist, psychiatrist, etc) Yes No
Please provide their name and reasons for therapy:_____

Has your child seen a mental health professional in the past? (school counselor, social worker, psychologist, psychiatrist, etc) Yes No

Is the child currently or in the past on any psychiatric medications Yes No
If so, please list_____

Does your child have a history of being teased or bullied? Yes No
If so, where_____

EXERCISE LOG: Please keep track of your daily activities for one day. **If your child did not have any exercise or chores, please check the box below to acknowledge no activity during that time.**

Date	Exercise/Chores	Minutes/Steps

□□ **I did not have any physical activity/chores for this day.**

Place Label Here
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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)	

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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)	

Place Label Here
or

_____

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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