MUNROE-MEYER INSTITUTE
Pediatric Feeding Disorders Program

Pediatric Feeding Disorders Program

Instructions:

Please complete this online screening form and 3-day food record BEFORE your child's evaluation. Also, please mail us:

1. Your child's most recent medical evaluation and medical records.
2. Records of therapy (previous and current) for your child's feeding difficulties.
3. A current videotape sample of a "typical" mealtime with your child (if available).

You may send this information via mail to:

The Munroe-Meyer Institute
Pediatric Feeding Disorders Program
985450 Nebraska Medical Center
Omaha, NE 68198-5450
Attn: Melissa Nieman-support services
Telephone: 402.559.7039

Fax: 402.559.5950

If you have any questions or need assistance please call Melissa Nieman at 402.559.7039 or email mnieman@unmc.edu. Thank you very much for your interest in the Pediatric Feeding Disorders Program.

Sincerely,
Cathleen Piazza, Ph.D.
Director, Pediatric Feeding Disorders Program
Professor, Department of Pediatrics
Munroe-Meyer Institute
University of Nebraska Medical Center

BIOGRAPHICAL

Child's Name: _____ Date of Birth: _____

Caregiver/Legal Guardian

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____(h) _____ (w) _____ (c)

Has your child been seen before at the Munroe-Meyer Institute: ☐ Yes ☐ No

REFERRAL INFORMATION

Who referred you to the Pediatric Feeding Disorders Program at the Munroe-Meyer Institute?

Name: _____

Affiliation: _____

Address: _____

CURRENT MEDICAL PROVIDERS

Name of Primary Care Physician: _____Affiliation: _____

Address: _____

Telephone: _____

Name of Gastroenterologist: _____Affiliation: _____

Address: _____

Telephone: _____

INSURANCE

Who is responsible for this account?_____
Relationship to patient _____
Insurance Company _____
Group # _____Policy # _____
Is the patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's name _____
Birthdate _____ SS# _____
Relationship to patient _____
Employer _____
Insurance Company _____
Group # _____ Policy #_____

SCHOOL/DAY CARE

Name of School:_____ Teacher:_____
Address:_____ Phone:_____

In your opinion, would the school/day care be willing to follow a treatment for your child's feeding problems?
☐ Yes ☐ No

PRIOR PROFESSIONAL CONTACTS

Please list all past and current therapies your child has received by completing each of the boxes below.

Service	Start/End Date (month/ year)	How often?	Length of each therapy session	Did therapy focus on feeding?	Effect of therapy for feeding problem	Therapist information (name, address, telephone)
Occupational Therapy ☐ Yes ☐ No		☐1x/month ☐2x/month ☐1x/week ☐2x/week ☐3x/week ☐_____	☐15 min ☐30 min ☐45 min ☐1 hr ☐1.5 hr ☐_____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	
Physical Therapy ☐ Yes ☐ No		☐1x/month ☐2x/month ☐1x/week ☐2x/week ☐3x/week ☐_____	☐15 min ☐30 min ☐45 min ☐1 hr ☐1.5 hr ☐_____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	
Speech ☐ Yes ☐ No		☐1x/month ☐2x/month ☐1x/week ☐2x/week ☐3x/week ☐_____	☐15 min ☐30 min ☐45 min ☐1 hr ☐1.5 hr ☐_____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	
Early Intervention ☐ Yes ☐ No		☐1x/month ☐2x/month ☐1x/week ☐2x/week ☐3x/week ☐_____	☐15 min ☐30 min ☐45 min ☐1 hr ☐1.5 hr ☐_____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	
Nutrition ☐ Yes ☐ No		☐1x/month ☐2x/month ☐1x/week ☐2x/week ☐3x/week ☐_____	☐15 min ☐30 min ☐45 min ☐1 hr ☐1.5 hr ☐_____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	
Others: (please list)		☐1x/month ☐2x/month ☐1x/week ☐2x/week ☐3x/week ☐_____	☐15 min ☐30 min ☐45 min ☐1 hr ☐1.5 hr ☐_____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	

MEDICAL INFORMATION

Personal/Social History

Child lives with: ☐ mom ☐ dad ☐ both parents ☐ other caregiver: _____
Siblings/ages _____
Grades in school/performance _____
# of days missed (school &/or daycare) _____
Anyone smoke at home _____
Pets at home _____
Activities/interests _____
Recent stress or change _____

Birth History

How many weeks pregnant were you when your child was born? _____
Was your child born by vaginal delivery or c-section? _____
What was your child's birth weight/length? _____lbs_____cms_____
Was your child's stool passage within the first 24 hours? _____
Were there any problems at birth? _____
Were there any problems during pregnancy? _____

Family History (e.g., colitis, inflammatory bowel disease, ulcerative colitis, Crohn's, colon polyps, colon cancer, celiac disease, irritable bowel syndrome, allergies, asthma, thyroid, liver, diabetes, mental health issues, or other medical conditions)
Please list _____

Gastrointestinal Symptoms

Trouble swallowing	☐ Yes ☐ No	_____
Nausea or vomiting	☐ Yes ☐ No	_____
Vomiting blood or bile	☐ Yes ☐ No	_____
Appetite change	☐ Yes ☐ No	_____
Heartburn	☐ Yes ☐ No	_____

Abdominal Pain: (if your child does not have abdominal pain, write N/A for the first question and go on to the next section)
How long has your child had abdominal pain? _____
How often does it happen? _____
At what time of the day does it happen?_____
How long does the pain last?_____
Any pain at night when sleeping?_____
Is the pain better or worse with food?_____
What type of food affects the pain?_____
Does the pain improve with a bowel movement?_____
What have you tried to help with the pain?_____
How much school is missed because of pain?_____

Bowel History

Is your child toilet trained? _____
Does your child wet the bed? _____
How often does your child have stools? _____
Are the stools: ☐ Hard formed, ☐ soft formed, ☐ pudding, or ☐ watery
Do the stools vary in consistency? _____
Does your child take laxatives to stool? _____
Does your child have accidents in his or her underwear? _____
Does your child exhibit any stool withholding behavior? _____
Any blood in the stools? _____ Any black/tarry stools _____
Any mucous in the stools? _____

Other GI
Liver disease _____
Gallbladder disease _____
Jaundice _____
Irritable bowel disease _____
Inflammatory bowel disease _____

Medical History
Current Diagnoses _____
Previous illnesses _____
Past surgeries/hospitalizations _____
Current medications and dosages: _____
_____
Allergies: Medications/Environmental/Seasonal _____
Allergies: Foods _____
Food intolerance? (e.g., lactose intolerance)_____
Previous illnesses _____
Past surgeries/hospitalizations _____
Are immunizations up-to-date? _____
If not up-to-date, what is delinquent? _____
Any developmental concerns? _____

Review of Systems
General
Weight loss ☐ Yes ☐ No
If yes, how much? _____lb; over what period of time did this weight change occur? _____
Weight gain ☐ Yes ☐ No
If yes, how much? _____lbs; over what period of time did this weight change occur? _____
Unexplained fevers ☐ Yes ☐ No
Unusual fatigue ☐ Yes ☐ No
Poor appetite ☐ Yes ☐ No
Poor sleeping ☐ Yes ☐ No

Skin
Eczema ☐ Yes ☐ No
Rashes ☐ Yes ☐ No

Ear Nose and Throat
Frequent ear infections ☐ Yes ☐ No
Sores in mouth ☐ Yes ☐ No
Sinus problems ☐ Yes ☐ No

Respiratory
Pneumonia ☐ Yes ☐ No
Asthma/wheezing ☐ Yes ☐ No
Chronic cough ☐ Yes ☐ No

Cardiovascular
Heart murmur ☐ Yes ☐ No
Heart disease ☐ Yes ☐ No

Genitourinary
Blood in urine ☐ Yes ☐ No
Pain with urination ☐ Yes ☐ No

Muscle/Skeletal
Joint pain/stiffness ☐ Yes ☐ No
Back pain ☐ Yes ☐ No

Hematology/Lymphatic
Enlarged lymph nodes ☐ Yes ☐ No
Excessive bruising ☐ Yes ☐ No
Bleeding of gums ☐ Yes ☐ No
Nose bleeds ☐ Yes ☐ No
History of anemia ☐ Yes ☐ No

Neurologic
Seizures ☐ Yes ☐ No
Frequent headaches ☐ Yes ☐ No
Migraine headaches ☐ Yes ☐ No
Unusual/excessive fussiness/irritability ☐ Yes ☐ No

Endocrine
Diabetes ☐ Yes ☐ No
Thyroid ☐ Yes ☐ No
Growth problems ☐ Yes ☐ No

Psychosocial
Anxiety ☐ Yes ☐ No
Depression ☐ Yes ☐ No
School avoidance ☐ Yes ☐ No
Recent stresses ☐ Yes ☐ No
Abuse (physical, emotional, sexual) ☐ Yes ☐ No
Insomnia/trouble sleeping ☐ Yes ☐ No
Drug/alcohol use ☐ Yes ☐ No

FEEDING HISTORY

Was there a time when you did not or were not able to give your child food or liquid by mouth?
☐ Yes ☐ No
How long? _____ How old was your child at the time? _____
Why? _____
Has this problem resolved? ☐ yes ☐ no if yes, when did it resolve? _____

Medical Tests
Please check if your child has had the tests below. Write down the date (as best as you can remember) when the test was done.

TEST	DATE
☐ MBS/OPMS/VFSS (swallow study)	
☐ Endoscopy	
☐ Gastric Emptying	
☐ pH probe	
☐ Upper GI	

Tell us if your child had or has any of the following:

	HAD	HAS NOW
Tracheostomy	☐	☐
Nasal cannula	☐	☐
OG-tube	☐	☐
NG-tube	☐	☐
G-tube	☐	☐
J-tube	☐	☐

Tube Feeding

Formula type: _____

Tube feeding schedule:

Time	Amount	Method (Pump, Gravity, Bolus)	Rate

If your child consumes oral feedings in addition to his/her tube feedings, please complete the "Meal Pattern" section below.

Does your child have a special diet? ☐ Yes ☐ No

If yes, what is it? _____

Your child's appetite is best described as (check one):

☐ poor
☐ fair
☐ good
☐ excellent
☐ eats too much

Does your child tell you when he or she is hungry? ☐ Yes ☐ No

How? ☐ tells me what he/she wants ☐ points at food/cabinet/refrigerator ☐ goes and gets the food/can/package ☐ cries ☐ takes me to the cabinet/refrigerator ☐ _____

Meal Pattern

Give us an example of when, where, what, and how much your child eats at each meal.

Meal	Time	Location	Food and Approximate Amount
Breakfast			
AM Snack			
Lunch			
PM Snack			
Dinner			
other Snack			

Height: ____cm___Weight: ____lbs___ List the date these measurements were taken: _____

Where were these measurements taken? ☐ pediatrician's office; ☐ other clinic/medical facility; ☐home

(PLEASE SEND A GROWTH CHART FROM YOUR PEDIATRICIAN'S OFFICE WITH GROWTH MEASURES FROM BIRTH, IF POSSIBLE).

Chronology

As an infant, my child was:

☐ bottle fed,
☐ breast fed,
☐ both,
☐ neither.

When bottle or breast fed, my child:

☐ drank very little,
☐ drank about half of what he/she was supposed to,
☐ drank most of what he/she was supposed to.

Tell us how old your child was (write the age in the column labeled "child's age") when you first started feeding each of the foods listed under "type of food" and tell us how your child reacted ("refused" or "accepted") to each type of food. For example, if you started cereal at 6 months, write 6 months under "child's age", next to the line with the word "cereal" in it, then check whether your child "refused" or "accepted" the cereal.

CHILD'S AGE	TYPE OF FOOD	CHECK ONE	
	Cereals	☐ REFUSED	☐ ACCEPTED
	Baby food	☐ REFUSED	☐ ACCEPTED
	Mashed food	☐ REFUSED	☐ ACCEPTED
	Table food	☐ REFUSED	☐ ACCEPTED

CURRENT FEEDING BEHAVIOR

Right now, my child eats in a
☐ regular chair ☐ booster seat ☐ high chair ☐ my lap ☐ _____.

During meals, my child ☐ eats with the rest of the family ☐ does not eat with the rest of the family.

How long does it take for your child to eat a meal? (check one)
☐ less than 10 minutes
☐ 10-20 minutes
☐ 20-30 minutes
☐ 30-40minutes
☐ 40-60 minutes
☐ more than 60 minutes

Current Feeding Skills
Check the one(s) that describe your child.

☐ Drinks from bottle
☐ Fed by caregivers
☐ Feeds self with fingers
☐ Feeds self with spoon
☐ Feeds self with fork
☐ Uses knife
☐ Drinks from cup/glass
☐ Drinks from straw
☐ Pours own drink
☐ Prepares own snack

Tell us about what your child does and does not eat RIGHT NOW. You may check more than one box for each food.

DOES EAT means that your child will eat the food most of the time when you serve it.
CAN EAT means that your child has the skill or ability to eat the food (even if he or she does not eat it).
NEVER EATS means that your child never or rarely will eat the food when you serve it.
CAN'T EAT means that your child does not have the skill or ability to eat the food even if he or she is willing to eat it.
HAS NOT TRIED means you have never given the food to your child.

	does eat	can eat	never eats	can't eat	has not tried
liquids	☐	☐	☐	☐	☐
baby food	☐	☐	☐	☐	☐
creamy foods (ice cream, yogurt)	☐	☐	☐	☐	☐
blenderized table food	☐	☐	☐	☐	☐
mashed table food	☐	☐	☐	☐	☐
chopped table food	☐	☐	☐	☐	☐
regular table food	☐	☐	☐	☐	☐
crisp foods (crackers, toast)	☐	☐	☐	☐	☐
chewy foods (meat)	☐	☐	☐	☐	☐
crunchy foods (carrots, celery)	☐	☐	☐	☐	☐

Write down the foods that your child will USUALLY eat when you serve them.

fruits _____

meats _____

starches_____

vegetables _____

liquids_____

junk food_____

Does your child's food habits and preferences match the family's? ☐ Yes ☐ No
Does your child eat little meals and snacks throughout the day? ☐ Yes ☐ No

ORAL MOTOR BEHAVIOR

My child had or has the following problems (you may check more than one):

PROBLEM	HAD	HAS NOW
Drooling	☐	☐
Poor suck	☐	☐
Can't bite off pieces of food	☐	☐
Difficulty with tongue control (tongue thrust, poor mobility)	☐	☐
Difficulty swallowing	☐	☐
Difficulty with lip control (can't keep his/her mouth closed)	☐	☐
Difficulty chewing (for children over 12 months)	☐	☐
Over sensitivity to food textures, temperature, spoon	☐	☐
Vomiting/Rumination	☐	☐
Teeth grinding	☐	☐
Coughing with certain foods/drinks	☐	☐
Gagging with certain foods/drinks	☐	☐
Grunting	☐	☐
Profuse perspiration (diaphoresis)	☐	☐
Aspiration	☐	☐
Other _____	☐	☐

OTHER BEHAVIORS

SLEEP

Check any that describe your child:

☐ Has difficulties going to sleep at night
☐ Tantrums when put to bed
☐ Has other behavior problems when put to bed
☐ Has difficulties going to sleep during naps
☐ Has difficulties staying asleep
☐ Has difficulties staying in bed
☐ Wants to sleep in caregiver's bed

My child goes to bed at _____pm.

My child wakes up at _____am.

My child takes a nap from _____ to _____ and _____ to _____.

OTHER BEHAVIOR PROBLEMS

Does your child have any other behaviors that you think are a problem? Check any one that describes your child's behavior.

- ☐ Doesn't do what he/she is told
- ☐ Temper tantrums
- ☐ Verbal abuse/argues with others
- ☐ Hurts other people
- ☐ Throws things
- ☐ Bothers other people
- ☐ Makes sounds or noises that bother people

Attentional Deficits
- ☐ is overactive
- ☐ doesn't pay attention, but not over active

Self-stimulation
- ☐ Body rocking
- ☐ Hand flapping
- ☐ Nail biting
- ☐ Thumb sucking
- ☐ Masturbation
- ☐ Other _____

- ☐ Pica
- ☐ Breaks things
- ☐ Steals
- ☐ Lies
- ☐ Sets fires
- ☐ Runs away

Self-Injury
- ☐ Head-hitting
- ☐ Head-banging
- ☐ Arm/hand biting
- ☐ Eye gouging
- ☐ Other _____

Complains of aches and pains
- ☐ Headaches
- ☐ Stomachache
- ☐ Other

- ☐ Tics
- ☐ Pulls out own hair
- ☐ Phobias
- ☐ Academic underachievement
- ☐ Skips school
- ☐ Separation Anxiety

Potty trained for urine, but has accidents
- ☐ during the day
- ☐ at night

- ☐ Soiling accidents

Accident Proneness
- ☐ Burns
- ☐ Poisons
- ☐ Falls

- ☐ Doesn't want to interact with people
- ☐ Poor social skills
- ☐ Depression
- ☐ Communication delays or deficits
- ☐ Repeats what people say
- ☐ Speech doesn't make sense
- ☐ Insists that everything is always the same way
- ☐ Doesn't know how to play with others

ADAPTIVE BEHAVIOR

Check the one that best describes your child's mental abilities.

☐ Normal intelligence ☐ Mild MR ☐ Moderate MR ☐ Severe MR ☐ Profound MR

Check the ones that describe your child (you may check more than one).

- ☐ Walks on his/her own
- ☐ Uses words or signs to communicate
- ☐ Toilet trained
- ☐ Can imitate a model
- ☐ Follows instruction
- ☐ Visually impaired
- ☐ Hearing impaired

What type of supervision does your child require (circle one)?

- ☐ Can be left unattended for brief periods
- ☐ Needs continuous monitoring, but can be accomplished in a group
- ☐ Requires 1:1 supervision

THREE DAY FOOD RECORD

Instructions: Record all food/fluid consumed during the next three days. Please be as specific as possible to ensure accuracy of the analysis. Record the amount eaten in either volume (tbsp, cup) or weight (g, oz) measurements. Include brand names and methods of preparation when appropriate

Note: If an altered texture is being consumed (e.g., pureed table food or wet ground), the yield of the "mixture" should be recorded as well as the amount consumed.

For example:

Date:	Food Item:	Yield:	Amount Eaten:
4/13/00	pureed chicken nuggets (4 nuggets, 1/2 c whole milk)	1 cup	1/3 cup
	carrots, canned		3 tbs.
	red grapes		25 ea.
	Kraft shells and cheese		1/2 cup
	Homemade Mango Shake (1 c mango, 1 1/2 c Wh. Milk)	2 cup	3/4 cup
	Tubefeeding: pediasure		480 cc/ml

Date:	Food Item:	Yield:	Amount Eaten:

Date:	Food Item:	Yield:	Amount Eaten: