Pediatric Feeding and Swallowing Center – Intake Form

Patient Name: _____ **Today's Date:** _____

Form Completed by: _____ **Relationship to client:** _____

Feeding Concerns

What is your major feeding concern? Please describe feeding problem.

_____

_____

_____

What is your feeding goal(s) for your child?

_____

_____

Please check the following healthcare professionals that are involved in your medical care:

Primary Care	Physician's Name: _____
Pediatrician	Physician's Name: _____
Other: _____	Physician's Name: _____
Other: _____	Physician's Name: _____

Past Medical History: Have you ever had any of the following conditions? (check all that apply)

ADD/ADHD	Diabetes	Osteoporosis / Osteopenia
Anemia	Difficulty Sleeping	Psychological Conditions
Anxiety	Dizziness	Seizures
Arthritis - Juvenile	Falls/ Near Falls	Stroke
Asthma	Hearing Problems	Swallowing Problems
Blood Clot	Heart Disease	Tuberculosis
Breathing Difficultly	Hepatitis	Vision Problems
Brain Injury	Hypertension	Other: _____
Broken Bones	Insomnia	_____
Cancer	Learning Disability	_____
Circulation Problems	Mental Illness	
Depression	Migraines	

Please check if your child has had the procedures below, and indicate date of tests and results:

☐ MBSS / OPMS	Date: _____	Results: _____
☐ Endoscopy	Date: _____	Results: _____
☐ Gastric Emptying	Date: _____	Results: _____
☐ pH Probe	Date: _____	Results: _____
☐ Upper GI	Date: _____	Results: _____
☐ Allergy Tests	Skin: _____	Blood: _____

Please list any surgeries or other conditions for which you have been *hospitalized,* including the approximate date and reason for the surgery or hospitalization:

Date	Surgery / Reason for Hospitalization
_____	_____
_____	_____
_____	_____

Are you currently taking any medications, vitamins, or supplements? Yes No

If you are attaching a medication sheet, check here:

If yes, please list all medications, dosage, and reason for taking each:

Medication / Vitamin / Supplement	Dosage	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**please make sure to notify us of any changes in medications that may occur during your treatment with us.*

Please list any allergies: _____

Describe any special diet or food intolerance:

_____

_____

Bowel Habits:

Frequency of Bowel Movements _____ times per day/week.

Consistency: _____ Mucous/Blood? _____

Feeding History

Breast? N Y If yes, at what age was your child weaned? _____

If currently breastfeeding, please describe schedule _____

Bottle fed? N Y Breast milk/Formula? Current formula: _____

Formula type: Powder/Concentrate/Ready-to-feed Please describe how you prepare (i.e. 4 oz water, 2 scoops powder): _____

_____

List any previous formulas & describe tolerance: _____

_____

_____

Other fluids presented in bottle: _____

_____

Solids: at what age where cereals/ baby foods introduced? _____ Any problems?

_____

Please circle the Stages of baby food that your child ate/eats: 1st/2nd/3rd/Toddler/DICES
Any problems? _____

When were table foods introduced? _____ Any problems? _____
_____

Does your child have any of the following? Please indicate when problem started.

Food Refusal (refusing all or most foods). Age started: _____

Food Selectivity by texture (eating only textures that are NOT age appropriate
Age started: _____

Food Selectivity by Type (eating a limited variety of foods. Age started: _____

Oral motor delays (problems with chewing, etc). Age started: _____

Dysphagia (problems with swallowing). Age started: _____

Abnormal preferences (temperature sensitive, color specific, particular brands).
Please describe: _____

Other feeding problems: _____

Current Meal Pattern
Which meal is your child's best? _____ Worst? _____

How long does a 'typical' meal take? _____

Please List preferred foods:

_____

_____

Please list non-preferred foods:

_____

_____

Please indicate your child's typical meal schedule. Number of meals/snacks:

_____

_____

Timing of meals/snacks:

_____

_____

Describe sequence in which food/liquids are offered (i.e. liquids first):

_____

_____

Feeding Behavior

Does your child experience any of the following with feeding?

Choking	Yes/No	Difficulty Chewing	Yes/No
Gagging	Yes/No	Coughing	Yes/No
Vomiting	Yes/No	Overstuffs mouth	Yes/No
Drooling	Yes/No	Teeth Grinding	Yes/No
Hypersensitive	Yes/No	Penetration/Aspiration	Yes/No
Sweating	Yes/No	Problem with biting	Yes/No

Other_____

Feeding Behavior

Does your child exhibit any of these behaviors at mealtimes? (Circle all that apply.)

Cries or screams	Messy	Refuses to Self-feed
Spits food out	Throws food	Eats to fast/slow
Plays with food	Picky Eater	Pushes food away
Does not suck	Refuses to swallow	Induces Vomiting
Leaves table	Wants 'down'	Refuses to open mouth
Eats non-food items	Clenches lips shut	Turns away from spoon

Other: _____

Do you think your child feels hunger? Yes No

How does your child indicate hunger? _____

What do you do if your child refuses to eat/drink?

_____

_____

Feeding Practices

Who feeds your child?

_____

Does your child eat better for a particular feeder? N Y Who? _____

Where does your child currently eat (circle all that apply):

Adult's Lap	Infant seat	High chair	Booster
Table/Chair	Sofa	Crib/Bed	Car seat
Modified Chair	Wheel chair	Tumble form	Roaming- Kitchen

Other: _____

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

Coax	Distract with TV/toys	Provide 'favorite' foods'
Threaten	Change meal schedule	Send to room/time out
Ignore	Offer reward	Force feed
Punish	Praise	Provide 'mini-meals'
Change foods	Allow grazing/roaming	Chase around house with food

Other: _____

What does your child drink from (circle please):

Bottle	Sippy Cup	Open Cup	Straw
Is your child able to self-feed? Yes No		spoon	fork

Is there something we did not ask, that you think would be helpful for us to know:

_____
_____
_____
_____
_____
_____

_____ _____ _____

Signature Relationship to child Date

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Personal Information:

Do you have any cultural or ethnic needs which you want accommodated? Yes No

Please Describe: _____

_____

Do you or the patient have a concern for your safety from someone in your home or community?

Yes No

How did you hear about us?

- ☐ Word of mouth
- ☐ Referred by physician:
- ☐ Internet
- ☐ Inova Navigator Referral
- ☐ Insurance provider
- ☐ Emergency Dept
- ☐ Urgent Care Center
- ☐ Hospital

We know you have a choice for your rehabilitation needs, thank you for choosing Inova.

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Food Intake Records

Instructions:
Please record all food/fluid consumed by your child for 2-3 days. The days chosen should represent your child's 'usual' intake. Do not record if your child is sick.

Name:_____

Meal type – Breakfast (B), Lunch (L), Dinner (D), Snack (S)

Date	Time	Meal Type	Food	Beverage	Amount

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Name:_____

Meal type – Breakfast (B), Lunch (L), Dinner (D), Snack (S)

Date	Time	Meal Type	Food	Beverage	Amount