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: ____________________________

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

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

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:

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<th>Date</th>
<th>Surgery / Reason for Hospitalization</th>
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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:

<table>
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<th>Medication / Vitamin / Supplement</th>
<th>Dosage</th>
<th>Reason for taking</th>
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*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? __________________________

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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.*
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)*

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