



Mt. Washington Pediatric Hospital, Inc.
Baltimore, Maryland 21209-4596

**Center for Nutritional Rehabilitation
New Patient Intake**

Place Label Here or Insert the following:

Last Name	First Name	Med Rec #
Date of Birth	Date of Service	

Today's Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____ Current Weight: _____ Ht: _____

Patient Ethnicity: (Please note: for informational purposes and is optional) **PLEASE CIRCLE**

0-Caucasian

3-Asian

1-African American

4-Other _____

2-Hispanic

Name of person completing the form _____ Relationship to child: _____

Do you have custody of child: ___ Yes ___ No

If not, who does: _____

Preferred Language: _____

Address: _____

Telephone: Home: _____ Cell: _____ Work: _____

E-mail Address: _____

Parent's name: _____

Referring Physician: _____ Phone: _____

Medical Diagnosis: _____

What are your feeding or nutrition concerns: _____

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: _____

At what age were solids introduced: _____

Described any difficulties: _____



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Has your child ever had any problem with the following? (Please circle)

Choking Gagging Coughing with solids/liquids Pain during swallow

If yes, **At what age did the problem start?** _____
 At what age did the problem stop? _____

Does your child have vomiting? If so, when does vomiting occur? (please circle)

During feeding After feeding Unrelated to feeding When upset

How often does vomiting occur? _____

How often does your child have a bowel movement? ____Times per day ____Times per week

Are stools usually (please circle): Watery Pasty Formed Runny

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

Does your child receive tube feedings (NG or G-tube)? ____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) _____

Describe if problems are occurring _____

Does your child avoid any consistencies? If yes, circle all that apply:

Smooth Crunchy Chewy Soft Mixed/lumpy



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What problem(s) does your child have with feeding? (please circle)

- | | | | |
|-------------------------|------------------------|--------------------|-------------------|
| Eats too fast | Eats too little | Messy eater | Skips meals |
| Eats too slow | Eats too much | Plays with food | Pocketing |
| Does not chew | Pushes food away | Leaves table | Cries or tantrums |
| Eats non-food items | Sneaks food | Refuses to swallow | Coughs |
| Spits food out | Refuses to open mouth | Drools | Vomits |
| Throws/drops food | Takes food from others | Grazing | Gags |
| Turns away from spoon | | Other _____ | |
| Picky eater (see below) | | | |

If picky eater, what foods are accepted? _____

What feeding techniques do you use with your child to get him/her to eat? (please circle)

- | | | | | |
|----------------------|--------------|-------------|-------------|-----------------------|
| Coax | Distraction | Limit foods | Threaten | Change meal schedule |
| Spank | Offer reward | Force feed | Ignore | Send to room/time out |
| Change foods offered | | Praise | Other _____ | |

Where do you feed your child? (please circle)

- Lap High chair/Booster seat Table/chair Other _____

Does your child self-feed? ____ Yes ____ No

Are any special utensils used? If so, please specify. _____

What does your child drink from? (please circle)

- Bottle Sippy cup Open cup Straw

Is it hard for you to tell if your child is hungry? ____ Yes ____ No

Does your child eat or have access to food between meals? ____ Yes ____ No

Does your child's food intake vary? _____

Does your child eat better for one caregiver than other? ____ Yes ____ No

If yes, please specify the individual: _____



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How long does a typical feeding/meal take? (please circle)

Less than 15 minutes 15-30 minutes 30-60 minutes More than 60 minutes

EATING STYLE:

How many meals are eaten outside the home per week: _____ **Where:** _____

Favorite foods/drinks: _____

Eats at the table with family: Always Never Sometimes

Eats in front of television: Always Never Sometimes

Any recent diet modifications? _____

What time of day is your child most hungry: (please circle)

Morning Afternoon Evening Late Night

Does your child eat before going to bed: ___No ___Yes, what is eaten: _____

Does your child wake up hungry at night? ___No ___Yes, what is eaten: _____

What does your child usually choose to drink: (please circle)

Soda- per day (ounces or cups): _____ Milk- per day (ounces or cups): _____

Juice- per day (ounces or cups): _____ Other: _____

Water- per day (ounces or cups): _____

Who grocery shops? (please circle)

Mother Father Grandparent Child Other: _____

Who prepares the meals? (please circle)

Mother Father Grandparent Child Other: _____

What is frequently eaten for snacks? _____

If there is a weight problem, what has contributed to this? (Please circle)

Boredom Emotional eating Snacking No activity Eating out Portions

Other _____



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PAST MEDICAL HISTORY:

Birth History:

Weight: _____ Length: _____ Full Term: **Yes** **No**

Which hospital? _____

If premature, at what week was child born: _____

Any problems during pregnancy/delivery? _____

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

Please detail any hospitalizations/surgeries/accidents/special medical treatments:

- | | |
|----------------------|----------------------|
| 1. _____ date: _____ | 4. _____ date: _____ |
| 2. _____ date: _____ | 5. _____ date: _____ |
| 3. _____ date: _____ | 6. _____ date: _____ |

DEVELOPMENTAL HISTORY: AT WHAT AGE DID YOUR CHILD:

Sit Up: _____ Walk: _____ Toilet Train: _____

IMMUNIZATIONS AND ALLERGIES:

Are Immunizations up to date? ____ Yes ____ No

Allergies (food, medication etc.) _____

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



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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

Full – Half – Step _____ M F

Family history of (please circle)

***This includes extended family- grandparents, aunts, uncles, cousins**

- | | | | |
|------------------------------|------------------|------------------------------|---------------------|
| Diabetes | Thyroid Problems | Obesity | Weight loss surgery |
| Peptic Ulcer | Reflux | Cancer | Gastric Ulcers |
| 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 | |
| Eating Disorder | Feeding Disorder | Irritable Bowel Syndrome | |
| 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 ____ No

Sitter: ____ Yes ____ No



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What is the quality of your child's relations with other kids:

Poor Fair Average Excellent

Is your child happy: ___Yes ___No, please explain: _____

Has your child ever been bullied or teased? ___Yes ___No

Receiving any of these services?(please circle) OT PT Speech times per week: _____

Which agency provides the service? ___ Infants and Toddlers ___School ___Private

IF IN SCHOOL:

Grade: _____ **What school does your child attend?** _____

School performance: Poor Fair Average Excellent

Does your child have either an IEP: ___Yes ___No **or 504 plan:** ___Yes ___No

If yes, please detail: _____

Do you have any concerns about your child's development or behavior? ___Yes ___No

If yes, explain. _____

Mother's highest level of education: _____

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

Father's highest level of education: _____

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

Primary caregiver's work schedule: (please circle)

Weekdays Weekends Week nights

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

REVIEW OF SYSTEMS:

Has your child ever been treated for the following conditions? (please circle)

ADHD ODD Anxiety Depression Mental Health Conditions



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Please return your completed form to MWPH.

Mail to: Mt. Washington Pediatric Hospital
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1708 West Rogers Ave
Baltimore, MD 21209

Or fax to us: 410-578-2654

Call us 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