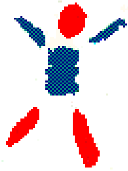
Patient's Name:
Date of Birth:
MRN:



Mt. Washington Pediatric Hospital, Inc.

Feeding Clinic

New Patient Information Form

1708 West Rogers Avenue ♦ Baltimore, Maryland 21209-4596
*(410) 578-5327 ♦ **FAX:** (410)578-2654*

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 3-Asian
1-African American 4-Other_____________
2-Hispanic

Address: ____
Telephone: Home: ____
E-mail Address: ______________________________
Parent's name: ________________________________ Work Telephone: ______________
Referring Physician: ____________________________ Phone: ______________________
Medical Diagnosis:____
Why are you interested in our program: ____

BIRTH HISTORY:

Weight:_________Length:________Full Term: **Yes** **No** Premature: **Yes** **No**

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: ____

Patient's Name:
Date of Birth:
MRN:

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

What foods do you avoid giving to your child: ____

What is your major concern about your child's feeding?____________________________________

____

Is there evidence of pain during swallowing? ______ Yes ______ No

If yes, explain____

Has your child ever had any problem with the following?

Choking? ______ Yes ______ No
Gagging? ______ Yes ______ No

If yes,

a. At what age did the problem start?____________
b. At what age did the problem stop?____________

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. Runny
d. Pasty
e. Formed

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

Does your child have any food allergies?____ Yes ______ No

If yes, explain____

Does your child have any food intolerance? ____Yes ____No

If yes, explain____

Patient's Name:
Date of Birth:
MRN:

Does your child receive tube feeding? _______Yes _____No

What is the schedule?____

What rate is your child's tube-feed? _______________________________________

What formula is used for the tube feed?____________________________________

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

Describe if problems are occurring _______________________________________

What kind /type of food does your child eat and how frequently does he/she eat it? (Use the following as a guide: never = 0 times per week, seldom = 1-2 times per week, occasionally = 3=4 times per week, always = daily).

Food Type	*Never*	*Seldom*	*Occasionally*	*Always*
Fruit: oranges bananas, peaches, etc.				
Fruit Juice				
Cereal				
Bread/toast				
Starches/grains: muffins, donuts, pasta, crackers, pretzels, rice, etc.				
Combination foods: lasagna, macaroni & cheese, soup, pizza, etc.				
Fats: butter, oil, mayo, etc.				
Sweets: cookies, candy, cake, etc.				
Milk/Dairy: pudding, ice cream, yogurt, cheese, etc.				
Eggs				
Meat (red)				
Chicken				
Pork				
Fish				
Green veggies				
Yellow veggies				

Patient's Name:
Date of Birth:
MRN:

What consistencies does your child eat, can eat but doesn't, or can't eat? What consistencies had your child never tried?

Food Type	*Does Eat*	*Can eat*	*Cannot eat*	*Never tried*
Liquids/soups				
Strained baby food				
Creamy food (yogurt, ice cream, etc.)				
Blenderized table food				
Mashed table food				

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/gags
_____________ Turns away from spoon
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?

______ Lap
______ Infant seat
______ High chair (regular_____________adapted____________)
______ Booster seat
______ Table/chair
______ Modified chair (e.g., wheelchair, tumbleform chair, etc)
______ Stand/roam
______ Floor
______ Couch
Other____

Patient's Name:
Date of Birth:
MRN:

Question	Yes	No
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
Does your child have a predictable feeding schedule?	______ Yes	______ No
Does your child's food intake vary much from		
Meal to meal?	______ Yes	______ No
Day to day?	______ Yes	______ No
Is child likely to eat more at one meal than other meals?	______ Yes	______ No

If so, which meal and why?____

Question	Yes	No
Does your child eat better for one caregiver or the other?	______ Yes	______ No

If yes, please specify the individual:____

Question	Yes	No
Does your child refuse to touch certain food or objects?	______ Yes	______ No
Does your child object to certain smells?	______Yes	______ No

How long does the feeding take?

_______Less than 15 minutes
______ 15-30 minutes
______ 30-60 minutes
______ More than 60 minutes

Question	Yes	No
Does your child drool during feeding?	______ Yes	______ No
Can your child bite off pieces of food?	______ Yes	______ No
Does your child pocket food in his/her cheeks?	______ Yes	______ No
Does your child use any special utensils or cups?	______ Yes	______ No
Does your child drink from a bottle, sippy cup or cup?	______ Yes	______ No
Has your child's hearing been evaluated?	______ Yes	______ No

When? ____

What were results? ____

Question		Yes	No
Is your child attentive during meals?		______ Yes	______ No
Is your child's level of alertness	High	______ Yes	______ No
	Moderate	______ Yes	______ No
	Low	______ Yes	______ No
Does your child understand simple conversation?		______ Yes	______ No

Patient's Name:
Date of Birth:
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Does your child understand commands? ______ Yes ______ No

How does you child communicate?

Verbal	______ Yes	______ No
Non-verbal	______ Yes	______ No
Gestural	______ Yes	______ No
Electronic device	______ Yes	______ No

Does your child communicate food preferences? ______ Yes ______ No

Does your child sleep through the night? ______ Yes ______ No

If not, why?____

Does your child have difficulty with separation? ______ Yes ______ No

Do you have any concerns about your child's development? ______ Yes ______ No

If yes, explain.____

Has your child received any other feeding therapy? ______ Yes ______ No

If yes, explain.____

EATING STYLE:

How many meals eaten outside the home/ week: ______ Where: _________________________

Favorite foods: ____

Favorite drinks: ____

Number of meals a day: 1 2 3 4 5 6 more?______

Eats at the table with family: Always Never Sometimes

Eats in front of television: Always Never Sometimes

Is your child particular about certain foods: Yes No

If yes, to which ones: ____

Is your child on a special diet: Yes No

If yes, which one(s): ____

Does family eat between meals: Yes No

What is eaten for snacks: **PLEASE CIRCLE**

0-Cookies/Cakes	3-Sandwiches	6-Yogurt
1-Fruit	4-Granola	7-Nuts
2-Chips	5-Cereal	8-Candy

Patient's Name:
Date of Birth:
MRN:

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

If yes, please explain: ____

PAST MEDICAL HISTORY:

Has your child had any special medical testing related to feeding problems: Yes No

If yes, please list: (i.e swallow study/upper GI/allergy testing)

____

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: _______________________________

IMMUNIZATIONS AND ALLERGIES:

Are Immunizations up to date? Yes No

Allergy to Food: No Yes, please list: ____

Allergy to Medicine: No Yes, please list: ____

Allergy to Latex: No Yes

Patient's Name:
Date of Birth:
MRN:

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	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	Thyroid Problems	Obesity	Weight loss surgery
Peptic Ulcer	Reflux	Cancer	Eating disorders
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	Gastric Ulcers
Irritable Bowel Syndrome		Sickle Cell Trait or Disease	
Thalassemia Trait or Disease		Other ________________	

SOCIAL HISTORY:

Caregiver marital status: **PLEASE CIRCLE**

Married
Divorced
Separated
Single
Widowed

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: ____________________________________

Patient's Name:
Date of Birth:
MRN:

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:____

Is your child receiving OT, PT or Speech services?
  Number of times per week _____________
  Which agency provides the service? ____ Infants and Toddlers ___School ___Private

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**
- High School
- GED
- Some College
- College Degree
- Graduate Degree

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

Primary caregiver's work schedule: **CIRCLE ALL THAT APPLY**
- Weekends
- Weekdays
- Days
- Nights

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

<u>DEVELOPMENTAL HISTORY:</u> AT WHAT AGE DID YOUR CHILD

- Sit Up: ______
- Walk: ______
- First Word: ______
- Toilet Train: ______

<u>MEDICATIONS</u>: Please list all medications within the last 3 months (include vitamins, health food remedies, etc.)____
____

Patient's Name:
Date of Birth:
MRN:

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

			Comments
Allergy	Yes	No	______________________
Bleeding Tendency	Yes	No	______________________
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	______________________
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	______________________
Gagging	Yes	No	______________________
Vomiting	Yes	No	______________________
Frequent ear infections	Yes	No	______________________

Has your child ever been treated for the following conditions:

			Comments:
ADHD	Yes	No	______________________
ODD	Yes	No	______________________
Anxiety	Yes	No	______________________
Depression	Yes	No	______________________
Mental Health Conditions	Yes	No	please describe______________
Legal issues	Yes	No	______________________

Thank you for taking the time to complete this questionnaire and for returning it to us in the self addressed stamped envelope.