Patient's Name: _____
Date of Birth: _____

Mt. Washington Pediatric Hospital, Inc.

Feeding Clinic

New Patient Information Form

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

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 concerns: _____

_____

Food allergies? ____No ____Yes (if yes, explain)_____

Food Intolerance? ____No ____Yes (if yes, explain)_____

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: _____

Patient's Name: _____
Date of Birth: _____

Has your child ever had any problems 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? ____Yes ____No
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

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?_____

Patient's Name: _____
Date of Birth: _____

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 or the other? ____ Yes ____No

If yes, please specify the individual:_____

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:_____

Patient's Name: _____
Date of Birth: _____

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):_____

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: _____ First Word: _____ 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.)_____

_____

FAMILY HISTORY:

Who lives in the home with your child?_____

Patient's Name: _____
Date of Birth: _____

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
Full – Half – Step	_____	M F
Full – Half – Step	_____	M F
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

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

Patient's Name: _____
Date of Birth: _____

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

If yes, please detail:_____

Does your child understand commands? ____ Yes ____No

How does your child communicate? (please circle)
Verbal Non-verbal Gestural Electronic device

Does your child communicate food preferences? ____ Yes ____No

Does your child sleep through the night? ____Yes _____ No

Does your child have difficulty with separation? ____Yes ____ No

Describe: _____

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:_____

<u>REVIEW OF SYSTEMS</u>:

Has your child ever been treated for the following conditions? (please circle)
ADHD ODD Anxiety Depression Mental Health Conditions

Does your child have any of these symptoms: (please circle)

Allergy	Bleeding Tendency	Headaches	Morning Headaches
Trouble breathing	Shortness of breath	Heavy breathing	Asthma
Snoring	Snores loudly	Mouth open(day)	Heartburn
Abdominal pain	Constipation	Diarrhea	Bedwetting
Joint problems	Tired in morning	Sleepy in school	Easily distracted
Difficulty organizing	Interrupts conversations	Wears glasses	Gagging
Trouble following directions	Vomiting	Frequent ear infections	Urinary problems

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FOOD INTAKE LOG Fill out three days of food records, one sheet for each day. Under the column "Amount Consumed", do not use words like "pieces", "bites" or "sips". Instead use teaspoons, tablespoons, cups, or ounces. Under "Description", include the brand name of the food if it is a pre-made/packaged item.
Date & Day of Week:_____ Was child ill on this day? Y/N Vitamin/Mineral supplements taken: _____G-Tube feedings – if applicable (name formula, feeding schedule, volume of each feeding, and water flushes):
_____
_____
Formula Recipe – if applicable (*example*: 6 scoops Enfamil Lipil powder + 10 ounces water):
_____
Day's intake considered: □ Typical for Child □ More than Usual □ Less than Usual
_____

DAY 1 Time	**Place food was consumed** (home, school, restaurant, etc)	**Food, Beverages** (Meals and Snacks)		**Amount Consumed**
		Food/Beverage Item	Description (include Brand name of food)	
Example 8 am	home	cereal	Cheerios	2 TBSP
		milk	2%	1 oz

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DAY 2 **Time**	**Place food was consumed** (home, school, restaurant, etc)	**Food, Beverages** (Meals and Snacks)		**Amount Consumed**
		Food/Beverage Item	Description (include Brand name of food)	

DAY 3 **Time**	**Place food was consumed** (home, school, restaurant, etc)	**Food, Beverages** (Meals and Snacks)		**Amount Consumed**
		Food/Beverage Item	Description (include Brand name of food)	