

Phone 269-254-8130 | Fax 866-376-0467

www.santoshawellnesskzoo.com

**Patient Information**

|  |
| --- |
| Name: |
| Birthdate (mm/dd/yyyy): | Sex: ( ) Male ( ) Female  |
| Diagnosis:  |
| Physician Name: |
| Physician Office: |
| Reason for Referral:  |
| Would you like to receive text/email appointment reminders? ( ) Yes ( ) NoIf yes, provide your preferred number/email:  |

**Parent/Caregiver Information**

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| Parent #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) Mom ( ) Dad ( ) Foster Parent ( ) Other \_\_\_\_\_\_\_\_\_Parent #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) Mom ( ) Dad ( ) Foster Parent ( ) Other \_\_\_\_\_\_\_\_\_ |
|  Is your child adopted? ( ) Yes ( ) No  | Who does the child live with?: \_\_\_ Parent #1 \_\_\_ Parent #2 \_\_\_ Both Please explain the living situation (*if not living with both parents):*  |
| Address:  |
| Preferred Phone: Name:  |
| Alternate Phone: Name: |
| Preferred Email: |

**Emergency Contact Information**

|  |
| --- |
| Name: |
| Address:  |
| Phone: |
| Relationship to Patient:  |

**Specialists on the Care Team***For example, GI doctor, ENT doctor, Dietician/Nutritionist*

|  |  |  |  |
| --- | --- | --- | --- |
| *Name of Specialist* | *Specialty*  | *Location*  | *Date last seen*  |
|  |  |  |  |
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**Pregnancy**

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| *Complications during labor/delivery:*( ) NONE ( ) C-Section ( ) Emergency ( ) Forceps ( ) Vacuum ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *Complications/Health problems during pregnancy:*( ) NONE ( ) Gestational Diabetes ( ) Toxemia ( ) Premature Labor ( ) Pre-eclampsia ( ) Meconium aspiration ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medications during pregnancy: ( ) Yes ( ) No If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Drug/Alcohol use during pregnancy: ( ) Yes ( ) NoIf yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Birth Information**

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| --- | --- |
| Birth Weight: \_\_\_\_\_\_lbs \_\_\_\_\_\_oz | Birth Length: \_\_\_\_\_\_\_\_ inches |
| APGAR: | Gestational Age at Birth: |
| *Condition After Birth*( ) Full-Term ( ) Pre-mature ( ) NICU Stay (If yes, why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ( ) Oxygen ( ) Jaundice ( ) Heart Problems ( ) Feeding Tube ( ) Congenital Abnormalities Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any Testing Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Medical History**

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| Please note any of your child’s medical, developmental, and/or mental health diagnoses.( ) Reflux ( ) Asthma ( ) Slow stomach emptying ( ) Esophagitis ( ) Diarrhea ( ) Genetic/chromosomal abnormality – specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( ) Failure to Thrive ( ) Constipation ( ) Mental health diagnosis – specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( ) Other – specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Major Illnesses (if any): ( ) Ear Infections (how often? \_\_\_\_\_\_ what treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)( ) Seizures (how often? \_\_\_\_\_\_ what treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| Hospitalizations (if any):  |
| Surgeries (with dates):( ) Ear Tubes \_\_\_\_\_\_\_\_\_ ( ) Central Line \_\_\_\_\_\_\_\_\_ ( ) G-Tube \_\_\_\_\_\_\_\_\_ ( ) Heart Repair \_\_\_\_\_\_\_\_\_ ( ) Trach \_\_\_\_\_\_\_\_\_ ( ) Shunt \_\_\_\_\_\_\_\_\_ ( ) Tonsillectomy \_\_\_\_\_\_\_\_\_ ( ) Adenoidectomy \_\_\_\_\_\_\_\_\_ ( ) Frenulectomy \_\_\_\_\_\_\_\_\_ ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Allergies: ( ) Yes ( ) No If yes, please list: |
| Current Medications (list medication, dosage, and reason):  |
| Has your child ever had a vision test? ( ) YES ( ) NO Does your child wear glasses? ( ) YES ( ) NOIf yes, date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has your child ever had a hearing test? ( ) YES ( ) NO Does your child wear a hearing aid? ( ) YES ( ) NO If yes, date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has your child ever received services or additional supports (ie. OT, PT, Speech, Early On, IEP/504, tutoring in school, Special Education classroom, Resource Room, pull out groups in school)? ( ) YES ( ) NOIf yes, please list all and explain:  |
| Is your child aware of the problem? |

**Developmental Feeding History**

What concerns do you have about your child’s eating?

What do you hope to gain from this appointment?

Child’s current weight: \_\_\_\_\_\_\_ Child’s current height: \_\_\_\_\_\_\_

Is child currently allowed to eat by mouth? ( ) Yes ( ) No

Is child currently allowed to drink by mouth? ( ) Yes ( ) No

Does your child have any of the following symptoms when eating or drinking? (check all that apply)

* Gagging
* Coughing
* Vomiting
* Eats a limited variety of food/selective
* Slow weight gain
* Refuses to eat
* Spits out food
* Cries / screams
* Choking
* Limited volume/not eating enough
* Difficulty swallowing
* Refuses to swallow/holds food in mouth
* Difficulty progressing to table food
* Does not remain seated
* Throws food and/or utensils

What strategies have you tried to deal with your child’s eating difficulties?

* Distraction during meals (ie. Games, TV)
* Skipping meals
* Rewards
* Feeding child when he/she requests food
* Coaxing
* Forcing
* Allowing child to drink more fluids
* Giving preferred foods
* Punishment
* High calorie supplements/formula

Does your child ever drink formula? ( ) Yes ( ) No

If yes, what brand(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes to the above, did your child have difficulty bottle feeding? ( ) Yes ( ) No

At what age did you start spoon feeding? \_\_\_\_\_\_\_\_\_\_\_

Did your child have difficulty with this? ( ) Yes ( ) No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any of the following medical tests performed?

* Upper GI series
* Endoscopy
* Head CT scan
* Allery testing
* Milk scan
* pH probe
* Head MRI scan
* Modified barium swallow study
* Genetic (chromosome) testing
* Bone age film/x-ray

**Eating Environment**

Where does your child usually sit during mealtimes?

* Infant seat
* High chair
* Booster seat
* Chair at table
* Child stands up
* Child wanders around
* In front of TV
* Held in caregiver’s arms
* Sitting on caregiver’s lap
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where in the house is your child fed?

* Kitchen
* Dining room
* Living room
* Walking around
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

With whom does your child usually eat/drink?

At what other locations does your child eat/drink?

**Current Eating Skills**

Who feeds your child?

Please note your child’s current feeding skills:

1. Breastfeeding ( ) Yes ( ) No
	* How many times per day: \_\_\_\_\_\_\_\_\_\_
2. Bottle feeding ( ) Yes ( ) No
	* Position when eating: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* How many ounces per day: \_\_\_\_\_\_\_\_\_\_\_
3. Spoon feeding ( ) Yes ( ) No
4. Self-Feeding ( ) Yes ( ) No
	* Finger feeding ( ) beginning ( ) partially successful ( ) completely successful
	* Feeds self with spoon ( ) beginning ( ) partially successful ( ) completely successful
	* Feeds self with fork ( ) beginning ( ) partially successful ( ) completely successful
5. Drinking from cup ( ) Yes ( ) No
	* Type of cup: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Straw drinking ( ) Yes ( ) No

What does your child drink?

* Water
* Formula
* Breastmilk
* Nutritional supplement
* Juice
* Soda/tea
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Food Textures**

Please check your child’s current ability to eat each of the following food textures:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Texture | Eats easily | Eats w/ difficulty | Refuses | Cannot eat | Never tried |
| **Baby food** |  |  |  |  |  |
| **Pureed table food** |  |  |  |  |  |
| **Mashed table food** |  |  |  |  |  |
| **Meltable foods** *(ie. Puffs, veggie sticks)* |  |  |  |  |  |
| **Soft cubes** *(ie. Avocado, bananas, mandarin oranges)* |  |  |  |  |  |
| **Soft Mechanical – single texture** *(ie. Muffins, soft pastas, deli meats, scrambled eggs, hard boiled eggs)* |  |  |  |  |  |
| **Soft Mechanical – mixed texture** *(ie. Macaroni and cheese, chicken nuggets, French fries, blueberries)* |  |  |  |  |  |
| **Hard Mechanicals** *(ie. Crunchy crackers, hard cookies, tortilla chips, hard raw fruits with peels, unprocessed meat)* |  |  |  |  |  |

What foods does your child eat from each of the following food groups (please check all that apply):

|  |  |
| --- | --- |
| **Fruits** |  |
| **Vegetables** |  |
| **Grains**  |  |
| **Protein**  |  |
| **Dairy**  |  |

**What goal(s) would you like your child to work on while with us?**

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| --- |
|  |

*Thank you for taking the time to complete this form!*