
Phone 269-254-8130 | Fax 866-376-0467
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## 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 ( ) No<br>If yes, provide your preferred number/email: | |

## Parent/Caregiver Information

| | |
|---|---|
| Parent #1: _____ ( ) Mom ( ) Dad ( ) Foster Parent ( ) Other _____<br>Parent #2: _____ ( ) Mom ( ) Dad ( ) Foster Parent ( ) Other _____ | |
| Is your child adopted? ( ) Yes ( ) No | Who does the child live with?:<br>___ Parent #1 ___ Parent #2 ___ Both<br>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

*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 ( ) No

If yes, please list

_____

## Birth Information

| | |
|---|---|
| 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

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):<br><br>( ) Ear Tubes _____ ( ) Central Line _____ ( ) G-Tube _____ ( ) Heart Repair _____<br>( ) Trach _____ ( ) Shunt _____ ( ) Tonsillectomy _____ ( ) Adenoidectomy _____<br>( ) 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 ( ) NO<br><br>If yes, date _____ and results _____ |
| Has your child ever had a hearing test? ( ) YES ( ) NO Does your child wear a hearing aid? ( ) YES ( ) NO<br><br>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 ( ) NO<br><br>If 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:

A. Breastfeeding ( ) Yes ( ) No
   - How many times per day: _____

B. Bottle feeding ( ) Yes ( ) No
   - Position when eating: _____
   - How many ounces per day: _____

C. Spoon feeding ( ) Yes ( ) No

D. 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

E. Drinking from cup ( ) Yes ( ) No
   - Type of cup: _____

F. 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?

| |
|---|
| |

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