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 ( ) No If yes, provide your preferred number/email:	

Parent/Caregiver Information

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*

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): ( ) 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 ( ) NO If 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 ( ) NO If yes, please list all and explain:
Is your child aware of the problem?

Developmental History

Please list the approximate age your child accomplished the following and write any pertinent details:

Motor			
Lift head while on tummy		Crawled (Indicate Hand/Knee or Belly)	
Rolled over		Stood independently	
Sat independently		Walked independently	

Self-Care			
Dress/Undress self			
Button/zip clothes	( ) Yes ( ) No	Tie shoes	( ) Yes ( ) No
Potty trained - DAY	( ) Yes ( ) No	Potty trained – NIGHT	( ) Yes ( ) No

Sleep Hygiene	Sleeps through the night ( ) Yes ( ) No How many hours? __________ Where does child sleep? ____ Do they have a set bedtime routine? ( ) Yes ( ) No Does their routine include technology (ie. iPad)? ( ) Yes ( ) No Does anything specific help them sleep at night? ( ) Yes ( ) No If yes, please explain: ____ ____
Grooming	Tooth brushing: ( ) Independent ( ) Needs Help ( ) Dependent Hair brushing: ( ) Independent ( ) Needs Help ( ) Dependent Washing face: ( ) Independent ( ) Needs Help ( ) Dependent Personal Hygiene: ( ) Independent ( ) Needs Help ( ) Dependent *Please explain if needs help or dependent:*
Bathing	**Bath** ( ) Yes ( ) No **Shower** ( ) Yes ( ) No **Tolerates well:** ( ) Yes ( ) No Washes hair: ( ) Independent ( ) Needs Help ( ) Dependent Washes body: ( ) Independent ( ) Needs Help ( ) Dependent *Please explain if needs help or dependent:*
Any bowel/bladder difficulties? ( ) Yes ( ) No If yes, please explain:	
Is your child able to identify the following feelings? ( ) Needing to use the bathroom ( ) Tired ( ) Hungry ( ) Pain ( ) Thirsty ( ) Feeling hot/cold	
How do your child handle pain? ( ) normal response ( ) Over-reacts ( ) Under-reacts *Please explain:*	
Started solid foods	
Used eating utensils	
Drank from open cup	
Mealtime Participation	Sits through family meal ( ) Yes ( ) No Uses technology at the table ( ) Yes ( ) No Eats family foods ( ) Yes ( ) No

Does your child have a history of any trauma (*physical, sexual, emotion, neglect, medical*)? ( ) Yes ( ) No If yes, please explain:

Social Emotional – *describe how you child does in the following situations*	
Play well with others	
Follows directions	1-step directions: ( ) Yes ( ) No 2-step directions: ( ) Yes ( ) No 3+ step directions: ( ) Yes ( ) No
Develops peer relationships	Does your child make friends easily? ( ) Yes ( ) No *If no, please explain:*
Play skills	*Please describe your child's play skills:* Favorite toys: Do they use their imagination in play? Do they play well with others? (ie. Sharing, engaging in an activity with another child) Are there any activities they avoid? Do they enjoy social activities (ie. library story time, birthday parties)?
Controls emotions well	Frustration: Anger: Excitement: What strategies (if any) help your child calm down? Is your child able to identify their emotions?

Educational History

<table>
<tr><td colspan="2">What school does your child attend?</td></tr>
<tr><td>Grade:</td><td>How often does he/she attend:

_____ days per week _____ hours per day</td></tr>
<tr><td colspan="2">What are your child's strengths in school?</td></tr>
<tr><td colspan="2">What areas at school are the most difficult for your child?</td></tr>
<tr><td colspan="2">Has your child ever been suspended or expelled from a school? ( ) Yes ( ) No

If yes, please explain:</td></tr>
</table>

Developmental Feeding History

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

What do you hope to gain from this appointment? What are your goals for feeding intervention?

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: ___________
   - Ages child was breastfed: ____________
B. Bottle feeding ( ) Yes ( ) No
   - Position when eating: ____
   - How many ounces per day: ____________
   - Ages child was bottle fed: ______________
C. Spoon feeding ( ) Yes ( ) No
   - Age spoon feeding introduced (fed by parent/caregiver): __________
   - Age spoon feeding by self: _________
D. Self-Feeding ( ) Yes ( ) No
   - Age child began self-feeding: _________
   - 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: _________________________________
   - Age introduced: _________
F. Straw drinking ( ) Yes ( ) No
   - Age introduced: _________

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	Age Introduced	Eats easily	Eats w/ difficulty	Refuses	Cannot eat	Neve
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)*						

Does your child have specific sensory preferences for foods?

- Sweet ( ) PREFERRED ( ) NON-PREFERRED
- Sour ( ) PREFERRED ( ) NON-PREFERRED
- Bitter ( ) PREFERRED ( ) NON-PREFERRED
- Bland ( ) PREFERRED ( ) NON-PREFERRED
- Salty ( ) PREFERRED ( ) NON-PREFERRED

- Spicy ( ) PREFERRED ( ) NON-PREFERRED
- Smooth Purees ( ) PREFERRED ( ) NON-PREFERRED
- Chunky Purees ( ) PREFERRED ( ) NON-PREFERRED
- Soft Solids ( ) PREFERRED ( ) NON-PREFERRED
- Hard Solids ( ) PREFERRED ( ) NON-PREFERRED
- Hot Foods ( ) PREFERRED ( ) NON-PREFERRED
- Warm Foods ( ) PREFERRED ( ) NON-PREFERRED
- Room Temperature Foods ( ) PREFERRED ( ) NON-PREFERRED
- Cold Foods ( ) PREFERRED ( ) NON-PREFERRED

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

Fruits	
Vegetables	
Grains	
Protein	
Dairy	

What is your child's average intake of foods (normal, below average, excessive)?

- Breakfast: ______________________
- Lunch: ______________________
- Dinner: ______________________
- Snacks: ______________________

Thank you for taking the time to complete this form!