FEEDING CLINIC INTAKE

Atrium Health

PATIENT INFORMATION

Child's Name: _____ DOB: _____ Age: _____ Male/ Female: _____

Diagnosis/ Problem: _____

Parent/ Caregiver Name(s): _____

Contact Numbers: Day _____ Evening _____ Cell _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Numbers: Day _____ Evening _____ Cell _____

Child's Pediatrician: _____ Other Doctors/ Specialists: _____

Any Special Services: _____

Preferred Language for Healthcare Education: _____

BIRTH HISTORY

☐ Full Term ☐ Premature (# weeks early: ___) Complications: _____

NICU Stay (if yes, how long?): _____ Ventilator: ☐ Y ☐ N Feeding Tube: ☐ Y ☐ N

Delivery Type: ☐ Vaginal ☐ C-Section Birth Weight: _____

SOCIAL HISTORY

Who lives at home? _____ Pets: _____

Any Tobacco Exposure? ☐ Y ☐ N Any major life changes? ☐ Y ☐ N _____

Any Needs for Food, Shelter, and/ or Medication? _____

Any Travel Outside of the United States? ☐ Y ☐ N If so, where and when?_____

EDUCATIONAL HISTORY

Current School/ Daycare: _____ Days/ Times Each Week: _____

Grade Level: _____ Academic Concerns: _____

Special Services at School: _____

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MEDICAL HISTORY

Surgeries/ Hospitalizations: _____

_____

_____

Current Medications: _____ Allergies: _____

Medical/ Adaptive Equipment: _____ Up to Date on Immunizations? □ Y □ N

Please check **YES-NO-NA** with comments as needed in the chart below.

	YES	NO	N/A	Comments
BLOOD/ CIRCULATION				
Anemia				
Easy bruising or bleeding				
CARDIOVASCULAR				
Heart murmur				
Heart palpitations				
High blood pressure				
EYE, EAR, NOSE & THROAT				
Recurrent ear infections				
Hearing difficulties				
Runny nose/ nasal drainage				
Recurrent sinus infections				
Enlarged tonsils				
Trouble swallowing				
Vision difficulties				
GASTROINTESTINAL				
Constipation or diarrhea				
Reflux				
Nausea/ vomiting				
Bloating				
Abdominal pain				
GENITOURINARY				
Recurrent urinary tract infections				
Blood in urine				
Bed wetting				
MUSCULOSKELETAL				
Joint pain				
Joint swelling/ redness				
Muscle weakness				
NEUROLOGICAL				
Headaches/ migraines				
Dizziness				
Fainting				
PSYCHOLOGICAL				
Anxiety				
Depression				
RESPIRATORY				
Difficulty breathing				
Wheezing				
Pain with breathing				
Chronic cough				
Asthma				
SKIN				
Rashes				
Yellowing of skin				
Eczema				
Acne				
OTHER				
Fever				
Fatigue				

FAMILY MEDICAL HISTORY

Please check all that apply.

ILLNESS	PATIENT	MOTHER	FATHER	SIBLING	GRANDPARENT	OTHER
ADHD						
Anxiety Disorders						
Asthma/Reactive Airway						
Autism						
Celiac Disease						
Cerebral Palsy						
Constipation						
Crohn's Disease						
Cystic Fibrosis						
Depression						
Developmental Delay						
Diabetes						
Food or Drug Allergies						
Gastroesophageal Reflux						
Genetic Syndrome						
H. Pylori Infection						
Headache/Migraines						
Heart Disease						
Hepatitis						
Intellectual Disability						
Irritable Bowel Syndrome						
Kidney Disease						
Lactose Intolerance						
Liver/Gallbladder Disease						
Lupus						
Polyps						
Rheumatoid Arthritis						
Seizures						
Sickle Cell Trait/Disease						
Thyroid Disease						
Ulcerative Colitis						
Ulcers						
Other:						

DEVELOPMENTAL HISTORY

Developmental Concerns: _____ Therapies recommended/ received: _____

Has your child been diagnosed with any of the following?

	YES	NO	Comments
CURRENT DIAGNOSES			
ADHD			
Autism			
Developmental Delay			
Genetic Syndrome			
Intellectual Disability			
Other:			

Please check **YES-NO-NA** with comments as needed in the chart below.

	YES	NO	N/A	Comments
COMMUNICATION HISTORY				
Smiled by 3 months				
Has good eye contact				
Said first word by 18 months				
Combined words together by 24 months				
MOTOR HISTORY				
Sat up by 7 months				
Crawled by 12 months				
Walked by 18 months				
ORAL & FEEDING HISTORY				
Difficulties breast / bottle feeding				
Difficulty transitioning to solids (baby food/soft table food)				
Accepts liquids from cup (sippy/straw/open) by 18 months				
Tolerates touch to face and mouth				
Tube feedings				
History of aspiration				
Family history of feeding problems				
TOILETING				
Toilet trained by 4 years				
Behavioral problems with toilet training				

FEEDING CONCERNS & HISTORY

How is your child positioned when eating? (ex. sitting in high chair, on the floor, standing)
_____

Are there any other activities going on during meal time? (ex. TV, toys) _____

Who else is present for meals? _____

If your child does not feed him/herself, who feeds him/her? _____

Does your child eat more/ less, or different types of foods when he/she is fed by someone else or in a different location? □ Y □ N If so, please describe _____

How many times a day does your child eat? _____

Approximately how much liquid does your child drink at each meal? _____

Approximately how much food does your child eat at each meal? _____

What sequence is followed when offering foods and liquids at mealtimes?
_____

How long do meals take to complete? _____

How would you describe your child's appetite? □ Strong □ Variable □ Poor

How does your child show that they are hungry? _____

Please list preferred/easy foods your child eats: _____

Please list non-preferred/difficult foods: _____

Please check all that apply below.

Behaviors When Eating	Food & Liquid Types	Feeding Utensils
□ Crying	□ Regular liquids	□ Bottle
□ Gagging	□ Thickened liquids	□ Breast
□ Vomiting	□ Baby cereal	□ Sippy Cup
□ Coughing	□ Stage 1 baby foods (thin, smooth)	□ Cup
□ Spitting food out of mouth	□ Stage 2 baby foods (thick, smooth)	□ Straw
□ Regurgitating food	□ Soft mashed table food (lumpy)	□ Spoon
□ Holding food in mouth	□ Dissolvable, crunchy foods (puffs, graham crackers)	□ Fork
□ Getting down from the table	□ Table food	□ Finger feeding
□ Complaining of food stuck in chest/chest pain		
□ Chewing a long time		
□ Feel full after eating small amounts		
□ Other (please list)		

Pediatric Feeding Journal

Please observe your child's oral intake throughout the next 1-3 days. Please record the type of food/ drink given, the amount consumed, the time the food/ drink is presented and any responses or problem behaviors you observe (ex. coughing, gagging, spit out, shut mouth, refused):

	Day #1	Day #2	Day #3
Breakfast Time:			
AM Snack Time:			
Lunch Time:			
PM Snack Time:			
Dinner Time:			
After Dinner Snack Time:			
Additional Snacks/Meals Time:			

Thank you for taking the time to complete your child's history form and feeding journal. We look forward to working with your family and thank you for choosing Atrium Health to help meet your child's needs.

Therapist Signature: _____ Date: _____

Atrium Health
Levine Children's

Feeding Clinic Intake Form

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