

## PATIENT INFORMATION

**Child's Name:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
**Address:** \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Zip: \_\_\_\_\_ School: \_\_\_\_\_

**Parent/Caregiver's Name:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Phone: (mobile) \_\_\_\_\_ (work) \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**Parent/Caregiver's Name:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Phone: (mobile) \_\_\_\_\_ (work) \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Phone: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_

**Other Children/Adults in Home:**

Name	Age	Relationship

Primary home language: \_\_\_\_\_  
 Other languages spoken in home: \_\_\_\_\_  
 Reason for referral / Primary concern: \_\_\_\_\_  
 \_\_\_\_\_ Ho  
 w did you find us? Physician Friend Insurance Internet School Other \_\_\_\_\_  
 Person responsible for payment: \_\_\_\_\_

# HEALTH HISTORY

Person Completing History: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Prenatal and Birth History**

During this pregnancy and/or delivery, did mother or baby experience any complications? If so, please describe.

\_\_\_\_\_

\_\_\_\_\_

Length of pregnancy: \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Has your child ever been hospitalized? Yes No *If yes, when and describe:* \_\_\_\_\_

\_\_\_\_\_

Has your child had any other significant illnesses, injuries, or surgeries? *If yes, when and describe:*

\_\_\_\_\_

\_\_\_\_\_

Child's current medications: \_\_\_\_\_

Please list any specific food, medicinal, or environmental allergies: \_\_\_\_\_

Illnesses	Age	Severity	Developmental Changes
Pneumonia			
Influenza			
Asthma			
Encephalitis			
Meningitis			
Whooping Cough			
Allergies			
High Fever (104+)			
Ear Infections			
Seizures			
COVID-19			

**Prior Evaluations**

	<u>Date</u>	<u>Results</u>
Speech/Language	_____	_____
Occupational Therapy	_____	_____
Physical Therapy	_____	_____
Hearing	_____	_____
Vision	_____	_____
Neurological	_____	_____
Psychological	_____	_____
Other	_____	_____

*Please provide previous evaluation reports from other professionals or provide facility and/or name of evaluator to request records. This information may be helpful in assessing and planning of treatment for your child.*

Is there any additional information that will help us to better understand your child?

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## Feeding Assessment Intake

1. **What concerns do you currently have? (check all that apply)**
  - Will not eat enough food by mouth
  - Difficulty with solid foods/chewing. Describe: \_\_\_\_\_
  - Difficulty with liquids. Describe: \_\_\_\_\_
  - Refuses certain kinds of foods (crunchy, spicy, smooth, lumpy, hot, cold). Describe: \_\_\_\_\_
  - Other. Describe: \_\_\_\_\_
2. **When did you first notice feeding concerns?** \_\_\_\_\_
3. **Are there any known food allergies? Please list:** \_\_\_\_\_
4. **Are there any cultural or religious practices regarding food or affecting how we care for your child? If so, please describe:** \_\_\_\_\_
5. **Doctors involved with your child (check all that apply):**
  - Cardiology
  - Pulmonology
  - Gastroenterology
  - Other: \_\_\_\_\_
  - ENT
  - Allergy
  - Neurology
6. **Any history of tube feeds? If so, please describe (type[NG, G-tube, etc])/quantity/frequency):** \_\_\_\_\_
7. **Has your child ever had a swallow study? (Please bring copy of results, if possible.)**
  - No
  - Yes. Results: \_\_\_\_\_
8. **How many meals and snacks does your child usually eat per day?** \_\_\_\_\_ meals \_\_\_\_\_ snacks
9. **How many ounces of liquid does your child usually drink per day?** \_\_\_\_\_ ounces
10. **Foods my child likes:** \_\_\_\_\_  
\_\_\_\_\_
11. **Foods my child dislikes:** \_\_\_\_\_  
\_\_\_\_\_
12. **Where does your child eat meals and snacks?**
  - High chair at the table
  - Standard chair at the table
  - Toddler table
  - On the go
  - Other: \_\_\_\_\_
13. **How long do meal times typically last?** \_\_\_\_\_