# 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:

_____

How did you find us? Please select Other_____

Physician Referral Name: _____

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**

| | *Date* | *Results* |
|---|---|---|
| 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?

_____
_____
_____
_____
_____
_____

## 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?** _____