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PARENT INTAKE FORM
FEEDING DISORDERS CLINIC
Neurodevelopmental Pediatrics
Confidential
Today's Date:

DEMOGRAPHICS

Child's Name:
Date of Birth/Age:
Sponsor's/Parents' Names:
Sponsor's ID (Last four of SSN):
Primary Care Physician:
Primary Phone Number:
Email Contact:

FEEDING HISTORY

What are your specific concerns/worries/questions?

What do you think is the problem with your child's feeding and eating?

When did you or the doctor first notice or become concerned about your child's growth, feeding/eating skills?

Describe history of your child's feeding issues:

Describe your child's feeding history, include information such as breast or bottle fed, age when purees, table foods introduced, etc:

List current typical daily diet with approximate volumes/amounts of each food and liquid consumed:

If your child has a feeding tube- list formula type and feeding schedule and volumes:

Describe your child's appetite pattern:

List foods that your child will eat all of the time:

List foods that your child will eat some of the time:

List foods that your child has tried but does not like:

List foods that your child refuses to try:

List foods that you would like your child to try:

List any known or suspected food allergies:

How long does feeding or meal usually take to complete?

In what setting does your child eat? ☐ high chair ☐ child sized table and chair ☐ other:

Check feeding skills/activities that your child can currently do:

- ☐ Breastfeeding
- ☐ Drinks from bottle (list, type of bottle and nipple)
- ☐ Eats from spoon
- ☐ Holds own bottle or cup
- ☐ Drinks from cup (list type)
- ☐ Finger feeds self
- ☐ Uses spoon or fork to feed self

Does your child have any negative behaviors associated with feeding/eating? If yes, please check:

- ☐ Food refusal
- ☐ Holds food in mouth
- ☐ Spits out food
- ☐ Gagging
- ☐ Retching
- ☐ Turns head/body away
- ☐ Closes lips
- ☐ Pushes spoon away
- ☐ Crying
- ☐ Tantrums

Does your child have any history of coughing, gagging or choking with food or liquid?

MEDICAL INFORMATION

Birth History:
Length of pregnancy-
Any complications during pregnancy, labor or delivery?
Type of delivery-
Birth weight- Birth length-
Were there any medical problems after birth? If yes, explain.

Medical History:
List any current medical problems or diagnoses:

Any food allergies?
Any medication allergies?
Are immunizations up to date?
List any current medications?

Has your child ever been hospitalized or had surgery? If yes, please explain.

Check if your child experiences any of the following? If yes, please describe:

- ☐ Constipation-
- ☐ Diarrhea-
- ☐ Vomiting/frequent spitting up or regurgitation-
- ☐ Weight concerns-
- ☐ Food allergies-
- ☐ Environmental allergies-
- ☐ Eczema or other skin problems-
- ☐ Asthma-
- ☐ Wheezing-
- ☐ Pneumonia-
- ☐ Recurrent ear infections-
- ☐ Recurrent colds or sinus infections-
- ☐ Poor appetite-
- ☐ Excessive appetite-

Sleep:

Are you concerned about your child's sleep?
Where and with whom does your child sleep?
What time does your child get in bed/fall asleep?
Is there any snoring or night wakening?

Has your child had any of the following tests? If yes, please check and include result.

- ☐ Upper GI-
- ☐ Videoswallow study-
- ☐ pH probe
- ☐ Endoscopy/biopsy-
- ☐ Gastric emptying study-
- ☐ Milk scan-
- ☐ Bronchoscopy/laryngoscopy-
- ☐ Sweat chloride test-
- ☐ MRI or CT or x-ray- If yes, list body part-
- ☐ Genetic blood work-
- ☐ Any additional medical information:

DEVELOPMENT

Are you concerned about your child's behavior or development? Why?

Has your child lost any abilities? Please specify

Check skills that your child can perform:

Gross motor: ☐Sits alone ☐Cruises ☐Walks alone ☐Runs ☐Pedals tricycle

Language/Social: ☐Smiles ☐Coos ☐Babbles ☐Says mama/dada ☐Waves bye-bye
☐Follows commands with a gesture ☐Follows command without a gesture
☐Uses 2 word phrases ☐Uses 2 word sentences ☐Uses 3 or more word sentences
☐Points to show an interest

Number of words:

Fine motor- ☐Reaches for toys ☐Transfers toys hand to hand ☐Picks up small toy with thumb and finger
☐Scribbles ☐Stacks blocks ☐Places shapes in puzzle board

Self-help/adaptive: ☐Eats from spoon ☐Finger feeds self ☐Holds bottle or cup ☐Uses fork or spoon well

Temperament: These questions are about ***how*** your child is and has been most of his/her life.

Activity level

- □ Always moving and active
- □ Often still and calm

Sleep, appetite, bowels

- □ Easy to predict and get on a schedule
- □ Hard to predict and get on a schedule

Adaptation to changes in routine or daily activities

- □ Flexible
- □ Inflexible

React to new people or unfamiliar situations

- □ Warms up with time/slower to warm up
- □ Warms up quickly

Sensitivity to: sounds, touch, clothing

- □ Sensitive
- □ More tolerant

Intensity of feelings or emotions (either positive or negative)

- □ Intense responses
- □ More reserved responses

Distractibility

- □ Distractible
- □ More focused

Usual mood

- □ More often pleasant and cheerful
- □ More critical and analytical

Persistence

- □ Sticks with activities to completion
- □ Less focused on completing difficult tasks

Sensory Processing: Please list any concerns that you may have about your child's ability to process and respond to information related to his/her touch, hearing, vision, movement, taste or smell senses.

	Typical reaction	Atypical reaction
Touch/pressure/ texture		
Sound		
Vision		
Taste		
Smell		
Pain		
Other		

FAMILY/SOCIAL HISTORY

Does anyone in the family have any of the following : (check all that apply, past or present)					
	Mother	Father	Sibs	Mother's side	Father's side
Gastroesophageal reflux or other GI problems					
Developmental delays or learning problems					
Depression, Anxiety Disorders, or other mental health problems					
Birth defects, genetic syndromes					
Cerebral palsy					
Other (Describe)					

Do you have any other concerns or questions about your child's developmental or behavior?

Is there anything else you would like to make sure we know about your child?

Thank you for your time!
The Neurodevelopmental Pediatrics Feeding Team

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