Childhood Solutions, PC

Building a strong future for children, adolescents and their families

Jill Belchic-Schwartz, PhD ■ Suzanne Grossman Goldstein, PhD ■ Mara Kaplan-Kaliner, PhD

# Feeding Intake Questionnaire

**Date: ____/____/____**

| **Background Information** |
|---|
| **Name:** _____ **Sex: M or F** **DOB:____/____/____** |
| Address: _____ |
| City: _____ State: _____ Zip: _____ |
| Phone: _____ Cell: _____ |
| Person completing form: _____ Relationship to child: _____ |

| |
|---|
| **Child's Doctor:** _____ |
| Address: _____ |
| City: _____ State: _____ Zip: _____ |
| Phone: _____ |
| Who referred child for evaluation/consultation: _____ |

| |
|---|
| **What are your concerns or questions about your child?** _____ |
| When did you first become concerned? _____ |
| What caused you to become concerned? _____ |
| _____ |
| _____ |
| What would you like to accomplish during this evaluation or therapy? _____ |

**455 Pennsylvania Avenue ■ Suite 115 ■ Fort Washington ■ PA ■ 19034 ■ Tel: 215.653.0363 ■ Fax: 215.653.0361**

## Medical History

**Is child adopted? Yes or No** **In foster care? Yes or No**

**How old was mother when she became pregnant?** _____

**How far along was mother when pregnancy was recognized?** _____

**How long was the pregnancy? Full term** **Other (specify):** _____

**Did the mother experience any health problems during pregnancy (circle all that apply):**

***Inadequate weight gain*** ***Excessive weight gain*** ***High blood pressure***

***Gestational diabetes*** ***Protein in the urine*** ***Other:*** _____

**Did mother smoke during pregnancy: No** **Yes (how much):** _____

**Did mother drink alcohol during this pregnancy: No** **Yes (how much per week):** _____

**Birth hospital:** _____ **How long did labor last:** _____

**How was baby born (circle):** ***Vaginal delivery*** ***Cesarean delivery***

**Birth weight:** _____ **How long did baby stay in hospital:** _____

**Any problems during delivery:** _____

_____

**Did baby have any medical problems after birth:** _____

_____

_____

**Are you concerned that you may have done something or that something may have occurred during the pregnancy or delivery to cause your child's difficulties:**

_____

_____

**Is the child growing well (circle): Yes or No If no, explain:** _____

**Immunizations up-to-date (circle): Yes or No If no, explain:** _____

**Allergies (circle): Yes or No If yes, please specify:** _____

**Frequent ear infections (circle): Yes or No If yes, please specify:** _____

Seizures (circle): *Yes* or *No* If yes, please specify: _____

Please list any hospital admissions or emergency room visits for your child:

| Date | Hospital | Reason for admission |
|---|---|---|
| Date | Hospital | Reason for admission |
| Date | Hospital | Reason for admission |

Please list any medications child takes on a regular basis: _____

_____

_____

Has child's hearing and vision ever been checked (circle): *Yes* or *No* *If yes, where and what were the results:*_____

_____

Developmental History

**Which of the following can your child do? Please indicate approximate age when child became able to do each item.**

| **Age** | Gross Motor | Age | Fine Motor | Age | Language |
|---|---|---|---|---|---|
| | Get head up in prone | | Open hands | | Smile to others |
| | Roll over (front to back) | | Reach for objects | | Coo |
| | Roll over (back to front) | | Finger feed | | Laugh |
| | Sit unsupported | | Pincer grasp | | Babble |
| | Crawl | | Hold cup | | Wave bye-bye |
| | Pull to stand | | Use spoon | | Say dada or mama |
| | Walk alone | | Show hand preference | | Understand "no" |
| | Walk up stairs | | Remove some clothing | | Say first word |
| | Run | | Unbutton clothing | | Follow simple commands |
| | Pedal tricycle | | Button clothes | | Point to desired objects |
| | Skip | | Zippers & snaps | | Say 4 to 6 words |
| | Hop | | Tie shoes | | Say 2-word phrases |
| | Ride 2 wheeler | | Toilet trained | | Says 50 words |
| | | | | | States full name |
| | | | | | Uses complete sentences |
| | | | | | Holds conversations |

How clear is your child's speech? That is, how much of your child's speech can a stranger understand?

*All or almost all* *About half* *Less than half*

How old does your child act: _____

Has your child lost any abilities (explain): _____

_____

**Behavioral History**

How would you describe your child's personality:

As an infant or toddler: _____

As a child: _____

How does your child get along with other children: _____

_____

_____

What does your child like to do for play: _____

_____

_____

Does your child have difficulty with any of the following (circle all that apply):

*Sleeping* *Eating* *Tantrums* *Head banging* *Hitting* *Biting* *Lying* *Stealing*

*Mouthing or eating non-food items* *Impulsive* *Hyperactive* *Short attention span*

*Forgetful* *Aggressive* *Destructive* *Toileting* *Other:* _____

How do you handle these behaviors: _____

_____

_____

| **Educational History**<br>Please list all schools or early intervention programs your child has attended | | | |
|---|---|---|---|
| **Year** | **Child's Age** | **School** | **Grade or Type of Service** |
| | | | |
| | | | |
| | | | |

| **Educational History**<br>Please list all schools or early intervention programs your child has attended |
|---|
| **Does your child have difficulties in school or receive any tutoring or extra support? If yes, please explain:**<br>_____<br>_____ |

| **Previous Evaluations**<br>**Please list all previous evaluations your child has had** | | |
|---|---|---|
| Date | Type of Professional | Results |
| | | |
| | | |
| | | |

| Family History | | | | | |
|---|---|---|---|---|---|
| | Name | Age | | Highest Grade Level | Occupation |
| Father | | | | | |
| Mother | | | | | |
| | Name | Age | Sex | Any developmental concerns? | |
| Sibling | | | | | |
| Sibling | | | | | |
| Sibling | | | | | |

Is there anybody in the family with any of the following (circle all that apply):

*Developmental delay* *Mental retardation* *Learning disability* *ADHD*

*Speech/language delay* *Cerebral palsy* *Autism/PDD* *Seizure disorder*

*Anxiety* *Depression* *OCD* *Bipolar Disorder*

*Eating Disorder* *Schizophrenia* *Other:* _____

Who lives at home with the child? _____

| Feeding History<br>What are your concerns about your child's eating (please check all that apply) | | |
|---|---|---|
| ☐ gagging/coughing w/textures | ☐ choking | ☐ vomiting |
| ☐ limited volume/not eating enough | ☐ limited variety/selective eater | ☐ difficulty swallowing |
| ☐ refuses to eat | ☐ poor weight gain | ☐ difficulty advancing to table food |
| ☐ refuses to swallow/pockets food | ☐ other _____ | |

How old was your child when you first became concerned with his/her eating? _____

| What have you tried to manage your child's feeding problems (please check all that apply) | | |
|---|---|---|
| ☐ distraction during meals (e.g., tv) | ☐ force feeding | ☐ skipping meals |
| ☐ allowing child to drink more fluids | ☐ rewards | ☐ giving preferred foods |
| ☐ refuses to eat | ☐ poor weight gain | ☐ difficulty advancing to table food |
| ☐ feeding on demand | ☐ punishment | ☐ coaxing |
| ☐ high calorie supplements | ☐ other _____ | |

| Please check any of your child's medical diagnoses or conditions from the following list: | | |
|---|---|---|
| ☐ gastroesophageal reflux (GERD) | ☐ failure to thrive (FTT) | ☐ developmental delay |
| ☐ esophagitis | ☐ pulmonary issues/asthma | ☐ cardiac issues |
| ☐ neurologic issues | ☐ delayed gastric emptying | ☐ renal issues |
| ☐ autism spectrum disorder (ASD) | ☐ other _____ | |
| Does your child have any pain/discomfort associated with eating or drinking? _____ | | |

| Where does your child usually sit during mealtimes: | | |
|---|---|---|
| ☐ infant seat | ☐ highchair | ☐ booster seat |
| ☐ in front of television | ☐ on caretaker's lap | ☐ stands |
| ☐ wanders around | ☐ other _____ | |
| In what location of the house is your child fed: | | |
| ☐ kitchen | ☐ dining room | ☐ living room/family room |
| ☐ walking around | ☐ other _____ | |

| With whom does your child usually eat/drink: | | |
|---|---|---|
| ☐ alone | ☐ with parents | ☐ with siblings |
| ☐ with peers | ☐ other _____ | |

| Does your child do any of the following during a mealtime: | | |
|---|---|---|
| ☐ refuses to eat | ☐ tries to get out of seat | ☐ spits out food |
| ☐ cries/screams | ☐ gags/coughs | ☐ vomits |
| ☐ throws food/utensils | ☐ holds/pockets food in mouth | ☐ other _____ |

| Your child's appetite is best described as: | | |
|---|---|---|
| ☐ poor | ☐ fair | ☐ good |
| ☐ excellent | ☐ insatitable | ☐ other _____ |

| | | | |
|---|---|---|---|
| Is your child's appetite consistent across meals? | ☐ yes | ☐ no | Explain: |
| Does the child eat a little bit at a time all day long? | ☐ yes | ☐ no | Explain: |
| Does your child have strong preferences for food? | ☐ yes | ☐ no | Explain: |
| Does your child eat certain brands only? | ☐ yes | ☐ no | Explain: |
| Do you have to present the food the same way? | ☐ yes | ☐ no | Explain: |
| **How long does it take for your child to finish a meal?** _____ minutes | | | |

**The following statements MUST be signed by ALL patients, age 14 and over. If patient is under 14, parent must sign**

My signature below indicates that I have read and understood the office policies of Childhood Solutions, PC. I also understand that failure to pay for any services rendered can result in legal action.

Signature _____ Relationship to patient_____ Date ____/____/____

I give my consent to Childhood Solutions, PC to evaluate and/or treat myself or my child under 14 years of age.

Signature _____ Relationship to patient_____ Date ____/____/____

Please tell us anything else you think may be important for us to know: _____