Feeding Disorders Clinic
Unicorn Children's Foundation Clinics
Mailman Segal Center for Human Development
Nova Southeastern University

Intake Packet

Thank you for your interest in the Feeding Disorders Clinic at Nova Southeastern University. Prior to your evaluation we would like to get some background information about you and your child to help us prepare for your visit.

Instructions:

Please fill out all of the forms, including the three day food diary and return it as soon as possible, preferably prior to your evaluation appointment. Although you may have already given much of this information to other providers, having all of it together in one place will help our clinicians provide the highest quality of services possible. Thank you for collecting all of this information for us to best serve you and your child.

Please also obtain and include:

- Any evaluations related to feeding/GI concerns already performed. We are especially interested in swallow studies and tests performed by gastroenterologists and/or allergists. Your pediatrician or the specialty doctor will have access to these reports and can be mailed or faxed to the location listed below.
- Current height and weight of your child.
- The Three Day Food Diary found at the end of this packet.

The completed packet can be mailed or faxed to:

Nova Southeastern University
The Jim and Jan Moran Family Center Village
Unicorn Children's Foundation Clinics
Attn: Dr. Roseanne Lesack
3301 College Avenue
Fort Lauderdale, FL 33314

Fax: (954) 262-3744

If you have any questions or need assistance, please contact Dr. Roseanne Lesack (954) 262-CARE

FEEDING DISORDERS CLINIC
INTAKE PACKET

(Please Print)

Name of person completing form:	Today's date:

Primary reason for referral: (check all that apply)

☐My child is feeding tube dependent and accepts little food by mouth
☐My child mostly gets nutrition by drinking formula
☐My child has poor self-feeding skills
☐Other:_____
☐My child has lost weight (_____ pounds)
☐My child only eats certain foods/is extremely picky
☐ My child eats too much or is gaining weight

SECTION I: CHILD AND CAREGIVER INFORMATION

Child's name:	DOB:	Gender: ☐ Male ☐Female

Caregiver name(s):	Marital Status: ☐Married ☐Divorced
Child's legal guardian:	☐Separated ☐Single ☐Widowed ☐Other: _____
Mother's occupation:	Father's occupation:

List of people currently living in the household:

Name	Relationship to Child	Age

Primary phone no.:	Secondary phone no.:

Street address:			
P.O. box:	City:	State:	ZIP code:

E-mail address:

Has your child been seen at the Mailman Segal Center previously? ☐Yes ☐No

Which program saw your child last?	What was the date of the last visit?

Is your child covered by a private health insurance provider? ☐Yes ☐No

Name of insurance company:

SECTION II: REFERAL INFORMATION

Who referred your child to our program?

☐Dr. _____ ☐Insurance plan ☐Hospital ☐Self ☐Family ☐Friend ☐Other:_____

If referred by a physician, please provide us with their contact information below:

Street address:			
City:	State:	ZIP code:	Phone no:

SECTION III: MEDICAL HISTORY

Please provide us with some information about your child:

Current weight:	Current height:	Has a medical provider expressed concern regarding your child's weight and/or growth? ☐Yes. Explain:_____ ☐No

Current medications (please include all prescriptions, vitamins, over-the-counter medications, and herbal or alternative remedies):	
Allergies:	Allergy test(s): please include date of tests ☐Blood: ____/____/____ ☐Skin patch: ____/____/____ ☐Skin prick: ____/____/____ ☐Endoscopy:____/____/____

Surgical History: ***Has your child ever had any surgeries?*** ☐***Yes*** ☐***No***

Type of Surgery	Date

Who are the medical providers who currently treat your child?

Name	Specialty	Name of Practice	Phone Number

Please mark your child's current and former medical problems or diagnoses with an 'X':

Medical Problem/Diagnosis	Past	Current	Medical Problem/Diagnosis	Past	Current
Autism, PDD, or Asperger's			Gastroesophageal reflux		
Developmental or Speech delay			Chronic constipation		
ADHD			Chronic diarrhea		
Learning disability			Food allergies		
Intellectual disability			Lactose intolerance		
Traumatic brain injury			Seasonal allergies		
Depression/Bipolar disorder			Blind or severe vision impairment		
Anxiety Disorder or OCD			Deaf or severe hearing impairment		
Cerebral palsy			Delayed gastric emptying		
Spina bifida			Liver disease		
Seizure disorder			Endocrine disorder or problems with growth		
Diabetes, Type I or II			Heart problems		
Prematurity			Asthma or lung problems		
Kidney disease			Cancer		
Failure to thrive					
Other medical diagnoses:					

****Please bring test results/reports to your appointment****

Hospitalizations and procedures (attach extra sheet if needed):		
☐Swallow study (MBS/OPMS)	Date:	Result:
☐Endoscopy	Date:	Result:
☐Gastric emptying	Date:	Result:
☐pH probe	Date:	Result:
☐Upper GI	Date:	Result:
☐Colonoscopy	Date:	Result:
☐Blood transfusion	Date:	Result:
☐Other:	Date:	Result:
☐Other:	Date:	Result:

Feeding Tubes				
Type of Tube	**Dates**	**Formula Name**	**Amount (cc)**	**% of Daily Intake**
Nasogastric (NG-tube)				
Gastrostomy (G-tube)				
Jejunostomy (J-tube)				
Other:				

Breathing Tubes	
Type of Tube	**Dates in Use**

Significant Illnesses or Hospitalizations	
Illness/Reason for Hospitalization	**Date/Age**

Bowel Habits	
Frequency of bowel movements: _____ times per (circle one): day week	Consistency: ☐ Hard ☐ Soft ☐ Loose ☐ Watery
Is your child toilet trained? ☐Yes ☐ No	Are there any concerns with toileting? ☐No ☐Yes:_____

Family History

☐**Medical problems** ☐**Psychiatric or psychological problems** ☐**Developmental delay** ☐**Feeding difficulty**

Family Member	Relationship to Child	Diagnosis

Are your child's immunizations up-to-date? ☐ Yes ☐ No

If no, why?

Does anyone smoke in the home? ☐Yes ☐ No	Recent travel or camping? ☐ No ☐Yes: Where?_____
Exposure to creek, lake, or well water? ☐Yes ☐ No	What animals is your child around?

SECTION IV: BIRTH INFORMATION

Please provide us with some information about the birth of your child:

Baby was born: ☐Full term ☐Pre-term (Gestational Age:_____)	Birth weight:
Type of delivery: ☐Vaginal ☐Caesarian Section: ☐Planned ☐Emergency	
Where there complications or problems noted? ☐During pregnancy ☐After birth ☐None	
Comments:	
Did your child stay in the Neonatal ICU (NICU)? ☐No ☐Yes: Duration_____	
Comments/reason for stay:	

SECTION V: DEVELOPMENTAL INFORMATION

Has your child ever been diagnosed with a developmental disability or as having a behavioral problem? ☐Yes ☐No
(e.g. ADD/ADHD, autism, oppositional behavior, aggressive behavior, speech delay, motor delay, learning problems, etc.)

Date of Evaluation/Diagnosis	Type of Evaluation	Results/Diagnosis	Name of Doctor/Evaluator

Please list the approximate ages at which your child was able to:

Smile:	Roll over:	Sit alone:
Stand alone:	Walk:	Mimic adults:
Say single word:	Talk in sentences:	Follow instructions:
Urinate in toilet:	Have BM in toilet:	Get dressed:

Is your child currently in school, early intervention, day care, or other community activity? ☐Yes ☐No

Name of Facility	Grade	Teacher	How Often

Is school addressing feeding concerns? ☐No ☐Yes

If yes, how? Is this effective?

Please list any therapy or support services your child currently receives or has received in the past to address feeding concerns (e.g. speech therapy, occupational therapy, physical therapy, feeding therapy ABA/behavior therapy, early intervention, psychology)

Dates of Treatment	Treatment Program/Therapist/Specialist	Problems Addressed	Was intervention helpful? How?

What is your child's estimated cognitive functioning?

☐Above average	☐Normal intelligence	☐Mild mental delay	☐Moderate mental delay	☐Severe or profound mental delay

This estimated mental functioning is from:

☐School testing ☐Psychologist testing ☐My best guess

SECTION VI: FEEDING HISTORY

Is your child currently working with a dietician? ☐Yes ☐No

Please list name, how often, and goals if applicable:

Was your child breast fed? ☐ No ☐ Yes, until age _____.

At what age were solids introduced?

Describe any special diets that you feed your child.
(e.g. dairy free, vegetarian, etc.)

If your child is tube dependent and./or drinks formula, please answer the questions below:

What formula(s) does your child currently take by mouth?

What formula(s) does your child currently take via feeding tube?

Approximate % daily intake taken by the tube:	Amount of formula fed (cc's or calories/child's weight):

Please describe your child's feeding schedule and sample meal. Give approximate amounts.

	Sample/Typical Meal	Approximate Mealtime
Breakfast		
AM Snack		
Lunch		
PM Snack		
Dinner		
Snack		

Please check the boxes that describe your child's current intake of each of the following food types: **(check all that apply)**
(e.g. Check "Can eat" and "Won't eat" if your child can and has eaten carrots, but always refuses to eat.)

Consistency	Does eat	Can eat	Cannot eat	Won't eat	Never tried	Comment
Regular liquid	☐	☐	☐	☐	☐	
Thick liquid	☐	☐	☐	☐	☐	
Stage 1 or 2 baby food	☐	☐	☐	☐	☐	
Food prepared in blender	☐	☐	☐	☐	☐	
Ground or Stage 3 baby food	☐	☐	☐	☐	☐	
Creamy food (pudding, yogurt)	☐	☐	☐	☐	☐	
Mashed table food	☐	☐	☐	☐	☐	
Chopped table food	☐	☐	☐	☐	☐	
Regular table food	☐	☐	☐	☐	☐	
Crisp food (crackers)	☐	☐	☐	☐	☐	
Chewy food (meat)	☐	☐	☐	☐	☐	
Crunchy food (carrot)	☐	☐	☐	☐	☐	

Please list various foods, flavors, textures that are usually accepted by your child.	
Fruits	
Proteins (meats, eggs, nuts, beans)	
Starches (pasta, rice, cereal, breads)	
Vegetables	
Dairy products	
Sweets	

Describe the sequence in which food is offered to your child (e.g. liquids always first, etc.):

Does your child milk or formula? ☐ Yes ☐ No If so, how much? _____ (how many ounces per day)

Do you child's food habits and preferences match the family? ☐ Yes ☐ No

Does your child eat little meals and snacks throughout the day? ☐ Yes ☐ No

My child's appetite is best described as: ☐ Poor ☐Fair ☐ Good ☐Excellent ☐Eats too much

How many meals and snacks per day? _____ Meals _____ Snacks

How long does it take your child to finish a meal? ☐Less than 10 min ☐10-20 min ☐20-30 min ☐over 60 min

How does your child show hunger? _____

Who usually feeds your child?

Describe the environment/location of meals (e.g. in front of TV, with family):

Where is your child usually fed? ☐ Lap ☐Infant seat ☐ Table/chair ☐ Stand/roam ☐ Adaptive chair ☐Booster seat ☐ Floor ☐ High chair ☐Couch ☐Other: _____

What utensils are used during meals? ☐Spoon ☐Fork ☐Knife ☐ Finger feeds

Any concerns?

What drinking utensils are used? ☐ Baby bottle (Type:_____) ☐Sippy cup ☐Straw cup ☐Open cup

Any concerns?

SECTION VII: BEHAVIORS AND FEEDING DIFFICULTY

Please check any behaviors that are of concern to you:

☐ Refuses to open mouth	☐ Gags	☐ Throws or drops food
☐Spits out food	☐ Ruminates	☐ Cries/Tantrums
☐Turns away from food	☐ Vomits	☐ Making negative statements
☐ Refuses to swallow food	☐ Leaves table	☐ Screaming
☐Fails to chew food	☐Pushes food away	☐Aggression

Other: _____

Oral Motor Functioning		
Check any of these problems that occur for your child:		
☐ Drooling	☐ Lip control (keeping his/her mouth closed)	☐ Coughing
☐Continuous sucking; poor sucking	☐ Chewing (for children over 12 months)	☐ Gagging
☐Biting (independently biting off pieces of food)	☐ Hypersensitivity to food textures, temperature, spoon	☐ Profuse perspiration (diaphoresis)
☐ Tongue control (tongue thrust, poor mobility)	☐ Vomiting/Rumination	☐ Aspiration (wet-sounding or "gurgly" voice)
☐Swallowing	☐Teeth grinding	☐Packing food in mouth (holding in cheek, under tongue)
☐Overstuffing (too much in mouth at a time)	☐ Other oral motor concerns:	

Other Behaviors and Habits
What time does your child go to bed? _____ Wake up?: _____ Nap?: _____
Does your child have problems going to sleep at night? ☐ No ☐ Yes:_____
Does your child appear to enjoy social interaction? ☐ Yes ☐ No
Does your child have problems being away from you? ☐ No ☐ Yes:_____
Does your child require special supervision (e.g. to prevent self-injury)? ☐ No ☐ Yes:_____
Please list behaviors that cause significant problems for your child (e.g. tantrums, aggression, self-injury)?

ADDITIONAL COMMENTS
Please list any additional information you feel is important for us to know:

THREE DAY FOOD DIARY

Instructions: Write down all food and liquids consumed during the next three days. Record information as specifically as possible to help us best analyze your child's current diet. Be as specific as possible with regards to the amount eaten using volume (e.g., tbsp., cup) or weight (e.g., g, oz) measurements. Make sure to list brand names of food when possible and how food was prepared. If your child is currently tube fed, please identify if the food/formula was eaten by mouth or via the tube.

Additionally, if foods are presented at specific textures (e.g., pureed chicken breast, finely chopped steamed carrots, or fork mashed lasagna), the total amount of food presented should be recorded in addition to the total amount eaten.

For example:

Date	Food Item	Yield (Total Serving)	Amount Consumed
5/16/15	Pureed waffles (2 waffles, 1/4c whole milk)	1 cup	1/2 cup
	Peas, canned	1/2 cup	1/4 cup
	banana	1 whole	1 whole
	Mac n' cheese	1 cup	1/2 container
	Strawberry yogurt	1 container	1/2 container
	Tube feeding: Pediasure		550 cc

Date	Food Item	Yield (Total Serving)	Amount Consumed

Date	Food Item	Yield (Total Serving)	Amount Consumed

Date	Food Item	Yield (Total Serving)	Amount Consumed