Child/Family Intake

Patient Name: _____ Date:_____

Gender: _____ DOB: _____ Age:_____

Primary Language:_____ Secondary Language:_____

Childs address:_____

Primary phone #:_____ Alternate phone #:_____

Email address:_____

Allergies:_____

Special Diet (Ex. Gluten/Casein Free): _____

Diagnosis: _____

Parent/Caregiver Concerns: _____

_____

Parent/Caregiver goals for therapy treatment:_____

_____

Family information:

Parent/agency with legal custody:_____

Other individuals living in the household with child:

Name & Age	Relationship	Developmental Concerns
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent Allergies/ Dietary Restrictions:

_____

School Caregiver Information

Name of School/Daycare:_____Phone:_____

Contact Person:_____Days/Times attending:_____

Medical Information:

Pediatrician:_____ Practice:_____

Address:_____

Phone:_____ Fax_____

Last well visit:_____ Immunizations up to date?_____

Hx of seizures?_____ Hx of Asthma?_____

GERD/Reflux:_____

Other Doctors or Specialists following your child:
Allergist:_____
Audiologist:_____
Neurologist:_____
Developmental Pediatrician:_____
ENT:_____
Eye:_____
Gastro Intestinal:_____
Psychologist:_____
Other:_____

Medications/Supplements: Dosage/Frequency: Prescribing Physician:
_____
_____
_____
_____
_____
_____

Birth History:

Any prenatal complications; if so, please specify: Ex: nutrition, diabetes, preeclampsia, drug, tobacco, or alcohol use._____
_____

Type of delivery: _____Natural _____Induced _____C-section

Birth weight:_____
_____Premature _____Full-term _____Weeks Gestation

NICU stay? y / n Length of stay?_____
Reason for Stay:_____

Child's primary means of satiation: Breast Bottle Combination Feeding tube

Were any of the following problems present at birth? (if so explain)

___Required resuscitation _____
___Required oxygen_____
___Jaundice/ yellow_____
___Infection/ Sepsis_____
___Difficulty sucking or swallowing_____
___Fed by means other than bottle/breast (ie NG or G tube)_____
_____
___ Other (describe) _____

Child's health history: (Check any that apply and explain):

__Birth anomaly_____
___Ear Infections_____
___Swallowing/digestive (reflux, dysphagia, constipation)_____
___Sleep concerns_____
___Feeding concerns_____
___Heart Concerns_____
___Sinusitis/Tonsillitis_____
___Respiratory problems (asthma, pneumonia, croup)_____
___Head injury/ unconsciousness_____
___Seizures_____ Frequency_____ Duration_____
___Fractures_____
___Other_____

Please list any surgeries, ER visits, or hospitalizations (Include nature of visit, hospital, and when):

Family History:

Brief family history of parents and siblings, please check all that apply and explain:

___Congenital disorders_____
___Speech disorders_____
___Eating disorders_____
___Sleep disorders_____
___Psychological Dx (anxiety, depression, etc)_____
__ Other_____
_____

Developmental History:

Self help- gross/fine motor:

Speech:

Age your child used a pacifier:_____
Age your child first self fed:_____
Age your child crawled:_____
Age your child began to walk:_____

Age of first babble:_____
Age of first word:_____

Potty trained (if so at what age?) y / n _____

Current Health Status:

Glasses: Y / N Hearing Aid: Y / N
Current sleep patterns:_____
Frequency of urination:_____
Frequency of bowel movements:_____
Supplemental nutrition intake:_____

Current Eating/Feeding History:

Does your child drink from a (Circle one): Bottle Sippy cup Open Cup

Please circle all that apply for your child:

Finger feed

Use utensil to self-feed

Drink independently from a bottle, cup and/or straw

Please list any other habilitations or evaluations your child has had in the past (include when, where, frequency, duration, and reason):

Please list any concerns you have regarding your child's behavior that might impact their eating:

How do you respond to your child's behavior?

Does your child demonstrate a preference for specific food colors, textures, shapes?

What is your families typical eating routine?: (Breakfast, lunch, dinner)

Do you play electronics/allow toys at mealtime? Yes No

Do you "punish" your child for not eating well or refusing food?

Do you reward your child for eating non-preferred foods or eating well? If so, how?

Food Neophobia Scale: (Pliner and Hobden, 1992)

Rate for the following when answering questions 2,3,5,7 & 8
1= Disagree extremely
2= Disagree moderately
3= Disagree slightly
4= Neither agree nor disagree
6= Agree moderately
7= Agree extremely

Rate for the following when answering questions 1,4,6,9, & 10 (bold and italicized)
1= Agree extremely
2= Agree moderately
3= Agree slightly
4= Neither agree nor disagree
5= Disagree slightly
6= Disagree moderately
7= Disagree extremely

_____ ***1.My child is constantly sampling new and different foods.***
_____ 2. My child doesn't trust new foods.
_____3. If my child doesn't know what is in a food, they won't try it.
_____***4. My child likes foods from different countries.***
_____5. Ethnic food looks too weird to eat for my child.
_____***6. At dinner parties (friends/outings), my child will try new food.***
_____7. My child is afraid to eat new things they have never had before.
_____8. My child is very particular about the foods they will eat.
_____***9. My child will eat almost anything.***
_____***10. My child likes to try new ethnic restaurants.***

Parent/Caregiver signature:_____ Date:_____