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REHABILITATION HOSPITAL

Inpatient Feeding Program Questionnaire

Today's Date:

BACKGROUND INFORMATION

1. Child's Name:	2. Date of Birth:	3. Gender: ☐ *Male* ☐ *Female*
4. Parent/Guardian(s) Name(s):	5. Marital Status: ☐ *Married* ☐ *Single* ☐ *Divorced* ☐ *Separated* ☐ *Widowed* ☐ *Other:*_____	

6. List of People Currently Living in the Household:

Name	Relationship to Child	Age

7. What is your major concern regarding your child's feeding?

8. Referring Source:

MEDICAL HISTORY

9. Current medications *(please include all prescriptions, vitamins, over-the-counter medications, and herbal or alternative remedies)*:

10. Allergies:	11. Allergy Test(s): *(Please include date of tests)* ☐ Blood: _____ ☐ Skin Patch: _____ ☐ Skin Prick: _____ ☐ Endoscopies: _____

12. Has your child been diagnosed with a medical condition? ☐ *Yes* ☐ *No* (e.g. Failure to Thrive, Pre-maturity, Congenital Heart Defect etc)

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

13. Surgical History: *Has your child had any surgeries)?* ☐*Yes* ☐*No*

Type of Surgery	Age

14. Medical Procedures: *(i.e. endoscopies, radiology testing, upper GI, swallow study, motility study, other GI tests etc)*

Procedure/Reason for Hospitalization	Date

15. Significant Illnesses or Hospitalizations:

Illness/Reason for Hospitalization	Date/Age

the children's center
REHABILITATION HOSPITAL

Inpatient Feeding Program Questionnaire

16. Family History: ☐ *Medical Problems* ☐ *Psychiatric or Psychological Problems* ☐ *Developmental Delay* ☐ *Feeding Difficulty*

Family Member	Relationship to Patient	Diagnosis

BIRTH INFORMATION

17. Baby was born: ☐ *Full Term* ☐ *Pre-term (Gestational Age: _____)* | 18. Birth Weight:

19. Type of delivery: ☐ *Vaginal* ☐ *Caesarian Section:* ☐ *planned* ☐ *emergency*

20. Complications or problems noted? ☐ *During Pregnancy* ☐ *After Birth* ☐ *None*
Comments:

21. Did your child stay in the Neonatal ICU? ☐ *No* ☐ *Yes: Duration* _____
Comments/Reason for Stay?

DEVELOPMENTAL INFORMATION

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

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

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

Sit Alone		*Crawl*		*Toilet Trained* (bowel/bladder)	
Walk Alone		*First Words*		*Spoke Sentences*	

24. Is your child attending school, early intervention program, day care or other community activity?

Name of Facility	Date Enrolled	How Often

the children's center
REHABILITATION HOSPITAL

Inpatient Feeding Program Questionnaire

25. Please list any therapy or support services your child currently receives or has received in the past (i.e. speech therapy, occupational therapy, physical therapy, feeding therapy ABA/behavior therapy, regional center, early intervention, psychology?

Date of Treatment *From____ to_____*	Treatment Program/Therapist/Specialist	Problem(s) Addressed	Reason for Cessation of Treatment

FEEDING HISTORY

26. Is your child currently working with a dietician? ☐ *Yes* ☐ *No*
Please list name, how often and goals if applicable:

27. What modes of feeding do you currently use or have used in the past?

Feeding method	Age introduced/how long?	Any Problems Noted/Comments
☐ *Breast-fed* ☐ *Bottle-fed* ☐ *Finger Feeds* ☐ *Spoon* ☐ *Fork* ☐ *Knife* ☐ *Straw Drinking* ☐ *Sippy Cup* ☐ *Open Cup Drinking* ☐ *Feeding tube:* *(circle one)* ☐ *G-tube* ☐ *NG tube* ☐ *NJ tube* ☐ *Other:* _____		

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

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

30. Approximate % daily intake taken by the tube?

31. Amount of formula fed (cc's or calories/child's weight):

32. Please describe your child's feeding schedule:

33. Please check the box that describes your child's current intake of each of the following food types:

CONSISTENCY	Does eat	Can eat	Cannot eat	Wont eat	Never tried	Comments
Regular liquid	☐	☐	☐	☐	☐	
Thick liquid	☐	☐	☐	☐	☐	
Stage 1 or 2 baby food	☐	☐	☐	☐	☐	
Food prepared in blender	☐	☐	☐	☐	☐	
Ground or Stage 3 baby food	☐	☐	☐	☐	☐	

the children's center
REHABILITATION HOSPITAL

Inpatient Feeding Program Questionnaire

Mashed table food	☐	☐	☐	☐	☐	
Chopped table food	☐	☐	☐	☐	☐	
Regular table food	☐	☐	☐	☐	☐	
Crisp food (crackers)	☐	☐	☐	☐	☐	
Chewy food (meat)	☐	☐	☐	☐	☐	
Crunchy food (carrot)	☐	☐	☐	☐	☐	

34. Please list various foods, flavors, textures that are favorites/easy or dislikes/difficult

Favorite/Preferred/Easy	**Dislikes/Refuses/Difficult**

35. How does your child let you know he/she is hungry?

36. Who usually feeds your child?	37. Which other individuals can feed your child? What is their relationship to your child?

38. Where is the child usually fed?

☐ *Lap* ☐ *Table/Chair* ☐ *High Chair* ☐ *Stand/Roam*
☐ *Infant Seat* ☐ *Floor* ☐ *Couch* ☐ *Other*: _____

39. Describe the environment/location:

40. How long do meals typically last?	41. How much food is your child able to finish in a typical meal?

42. Please check any behaviors that are of concern to you. Please circle the behavior(s) most concerning to you.

☐ *Eats too fast*
☐ *Eats too much*
☐ *Refuses to open mouth*
☐ *Spits food out*
☐ *Turns away from food*
☐ *Refuses to swallow food*
☐ *Picky eater*
☐ *Eats non-food items*
☐ *Uses a bottle*
☐ *Reflux*
☐ *Eats too little*
☐ *Fails to chew food*
☐ *Gags*
☐ *Sneaks or steals food*
☐ *Vomits*
☐ *Drools*
☐ *Messy eater*
☐ *Leaves table*
☐ *Ruminates*
☐ *Eats too slow*
☐ *Other:* _____
☐ *Pushes food away*
☐ *Fails to suck*
☐ *Throws or drops food*
☐ *Cries or Tantrums*
☐ *Plays with food*

43. Please check any techniques that you have used to get your child to eat. Please circle the technique(s) that are the most effective

☐ *Threaten* ☐ *Forced feeding* ☐ *Model* ☐ *Limit foods*
☐ *Coax* ☐ *Change food offered* ☐ *Spank* ☐ *Offer small meals*
☐ *Offer reward* ☐ *Distract with play/toys* ☐ *Praise* ☐ *Ignore*
☐ *Send to time-out* ☐ *Change meal schedule* ☐ *Use TV/Video* ☐ *Other:*

44. What are your goals for therapy? (check all that apply)

☐ *Increase amount of food*
☐ *Increase variety of foods*
☐ *Improve mealtime behaviors*
☐ *increased weight gain*
☐ *Decrease/eliminate tube feeds*
☐ *Increase the textures of food*
☐ *Improve oral motor skills*
☐ *Decrease gagging during eating*
☐ *Decrease vomiting related to eating*
☐ *Resolve reflux or other GI issues*
☐ *Other:*

ADDITIONAL COMMENTS

45. Please list any additional information you feel is important to the evaluation and treatment of your child.

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REHABILITATION HOSPITAL

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_____
Print Parent Name

_____ _____
Signature Date

We will need the following information to complete the evaluation:
1. Most recent physician notes
2. Most recent outpatient feeding therapy notes
3. Growth chart
4. Most recent lab test results
5. Most recent specialist notes (GI, ORL, etc.)
6. EGD report
7. Swallow study report

This information can be faxed to 844-785-7681.

In some situations we may require you to bring your child in for an in person evaluation prior to admission. Our admissions department will coordinate this appointment with you if needed. If you have any questions or concerns regarding this process please reach out to the admissions/referral department at 405-470-2247 or email Referrals@tccokc.org.

Thank you for allowing us to participate in the care of your child.