



the children's center
REHABILITATION HOSPITAL

Inpatient Feeding Program Questionnaire

Today's Date:

BACKGROUND INFORMATION

1. Child's Name:	2. Date of Birth:	3. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
4. Parent/Guardian(s) Name(s):	5. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> 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. Primary Care Provider:	Phone Number:	
9. Referring Source:	Phone Number:	

MEDICAL HISTORY

10. Current medications (please include all prescriptions, vitamins, over-the-counter medications, and herbal or alternative remedies):			
Medication	Dose (mg)	How often and what time?	
11. Allergies (medications or food):	12. Allergy Test(s): (Please include date of tests and copy of results) <input type="checkbox"/> Blood: _____ <input type="checkbox"/> Skin Patch: _____ <input type="checkbox"/> Skin Prick: _____		
13. Has your child been diagnosed with a medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No (e.g. Failure to Thrive, Pre-maturity, Congenital Heart Defect etc)			
Diagnosis	Date/Age at Diagnosis	Testing/Results	Doctor/Evaluator
<input type="checkbox"/> Reflux <input type="checkbox"/> Vomiting <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Constipation <input type="checkbox"/> Aspiration <input type="checkbox"/> Prematurity <input type="checkbox"/> Eosinophilic Esophagitis <input type="checkbox"/> Cleft lip/palate <input type="checkbox"/> Delayed gastric emptying or dysmotility <input type="checkbox"/> Other			
14. Surgical History: Has your child had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No			



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Type of Surgery	Date/Age	
15. Medical Procedures: <i>(i.e. endoscopies, radiology testing, upper GI, swallow study, motility study, other GI tests etc)</i> Procedure/Reason for Hospitalization	Date/Age	
16. Significant Illnesses or Hospitalizations: Illness/Reason for Hospitalization	Date/Age	
17. Family History: <input type="checkbox"/> Medical Problems <input type="checkbox"/> Psychiatric or Psychological Problems <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Feeding Difficulty		
Family Member	Relationship to Patient	Diagnosis
BIRTH INFORMATION		
18. Baby was born: <input type="checkbox"/> Full Term <input type="checkbox"/> Pre-term (Gestational Age: _____)	19. Birth Weight:	
20. Type of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> Caesarian Section: <input type="checkbox"/> planned <input type="checkbox"/> emergency		
21. Complications or problems noted? <input type="checkbox"/> During Pregnancy <input type="checkbox"/> After Birth <input type="checkbox"/> None Comments:		
22. Did your child stay in the Neonatal ICU? <input type="checkbox"/> No <input type="checkbox"/> Yes: Duration _____ Comments/Reason for Stay?		

DEVELOPMENTAL INFORMATION

23. 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)



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

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

Sit Alone	
Walk Alone	

Crawl	
First Words	

Toilet Trained (bowel/bladder)	
Spoke Sentences	

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

Name of Facility	Date Enrolled	How Often

26. 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

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

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

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

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

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

31. Approximate % daily intake taken by the tube?

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

33. Please describe your child's feeding schedule:



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34. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thick liquid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stage 1 or 2 baby food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food prepared in blender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ground or Stage 3 baby food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mashed table food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chopped table food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Regular table food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crisp food (crackers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chewy food (meat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crunchy food (carrot)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

Favorite/Preferred/Easy	Dislikes/Refuses/Difficult

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

37. Who usually feeds your child?

38. Which other individuals can feed your child? What is their relationship to your child?

39. Where is the child usually fed?

- | | | | |
|--------------------------------------|--------------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Lap | <input type="checkbox"/> Table/Chair | <input type="checkbox"/> High Chair | <input type="checkbox"/> Stand/Room |
| <input type="checkbox"/> Infant Seat | <input type="checkbox"/> Floor | <input type="checkbox"/> Couch | <input type="checkbox"/> Other: _____ |

40. Describe the environment/location where your child eats (dining room, living room, TV):

41. How long does it take your child to finish a meal?

42. How much food is your child able to finish in a typical meal?

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



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

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

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Threaten | <input type="checkbox"/> Forced feeding | <input type="checkbox"/> Model | <input type="checkbox"/> Limit foods |
| <input type="checkbox"/> Coax | <input type="checkbox"/> Change food offered | <input type="checkbox"/> Spank | <input type="checkbox"/> Offer small meals |
| <input type="checkbox"/> Offer reward | <input type="checkbox"/> Distract with play/toys | <input type="checkbox"/> Praise | <input type="checkbox"/> Ignore |
| <input type="checkbox"/> Send to time-out | <input type="checkbox"/> Change meal schedule | <input type="checkbox"/> Use TV/Video | <input type="checkbox"/> Other: |

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Increase amount of food | <input type="checkbox"/> Decrease/eliminate tube feeds | <input type="checkbox"/> Decrease vomiting related to eating |
| <input type="checkbox"/> Increase variety of foods | <input type="checkbox"/> Increase the textures of food | <input type="checkbox"/> Resolve reflux or other GI issues |
| <input type="checkbox"/> Improve mealtime behaviors | <input type="checkbox"/> Improve oral motor skills | <input type="checkbox"/> Other: |
| <input type="checkbox"/> increased weight gain | <input type="checkbox"/> Decrease gagging during eating | |

ADDITIONAL COMMENTS

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

Parent Signature

Date

We will be requesting the following information from your child's providers and therapists 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

If you need assistance in obtaining any of the above information please reach out to us.

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.