PEDIATRIC NUTRITION CLINICAL PRACTICE INTAKE FORM

Name of person completing form/relationship:	Today's date:
Primary reason for referral: (check all that apply) ☐ My child accepts little food by mouth ☐ My child only eats certain foods/ picky ☐ My child has food allergies ☐ My child has lost weight (______ lbs.) ☐ My child eats too much/gaining ☐ My child has a specific disease/condition *(please state below)* ☐ Other:_________________________________ ____________________________________	

SECTION I: 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 II: 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:

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		

Medical Problem/Diagnosis	Past	Current	Medical Problem/Diagnosis	Past	Current
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:		
Other medical diagnoses:			Other medical diagnoses:		

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

Hospitalizations and procedures as applicable (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:

Feeding Tubes				
Does your child use a feeding tube? ☐ **Y** ☐ **N** **If yes, please fill out below information:**				
Type of Tube	**Dates**	**Formula Name**	**Amount (cc)**	**% of Daily Intake**
Nasogastric (NG-tube)				
Gastrostomy (G-tube)				
Jejunostomy (J-tube)				
Other:				

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

Bowel Habits	
Frequency of bowel movements: ________ times per ☐ day ☐ week	Consistency: ☐ Hard ☐ Soft ☐ Loose ☐ Watery

SECTION IV: BIRTH INFORMATION	
Please provide us with some information about the birth of your child:	
Baby was: ☐ Full term ☐ Pre-term (___ weeks)	Birth weight:
Type of delivery: ☐ Vaginal ☐ Caesarian Section: ☐ Planned ☐ Emergency	
Were there complications/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: FEEDING HISTORY	
Is your child currently working with a dietitian? ☐Yes ☐No Please list name, how often, and goals if applicable:	
Was your child breastfed? ☐ 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 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	
Sweets	
Describe the sequence in which food is offered to your child (e.g. liquids always first, etc.):	
Does your child drink milk? ☐ Yes ☐ No If so, how much? _________ (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? ☐10 min or less ☐10-20 min ☐20-30 min ☐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: ____