Mt. Washington Pediatric Hospital, Inc.
Baltimore, Maryland 21209-4596

Center for Nutritional Rehabilitation
New Patient Intake

Place Label Here or Insert the following:

________________________/____________ ____________
Last Name *First Name* *Med Rec #*

________/_______/_______ ____________________
Date of Birth Date of Service

Today's Date: ____________

Patient Name: ____
Date of Birth: _____________Age:_________ Current Weight: __________Ht: __________
Patient Ethnicity: (Please note: for informational purposes and is optional) **PLEASE CIRCLE**
0-Caucasian 3-Asian
1-African American 4-Other_____________
2-Hispanic
Name of person completing the form _____________________Relationship to child: __________
Do you have custody of child: ____Yes _____No
If not, who does: ______________________________

Preferred Language: ____
Address: ____
Telephone: Home: _________________Cell: ________________Work: ________________
E-mail Address: ______________________________
Parent's name: ____
Referring Physician: ___________________________ Phone: ______________________
Medical Diagnosis:____

What are your feeding or nutrition concerns: _______________________________________

____

Does your child have any food intolerance? ____Yes ____No

FEEDING HISTORY:

Breast fed: ____Yes ____No

If yes, how long: _________ **and if yes please circle one**: **Pumped** or **Nursed**

Describe any difficulties with breast feeding/nursing: ___________________________

What infant formulas were used: ____

At what age were solids introduced: _______________________________________

Described any difficulties: ____

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Has your child ever had any problem with the following? (Please circle)
Choking Gagging Coughing with solids/liquids Pain during swallow

If yes, At what age did the problem start?_______
At what age did the problem stop?_______

Does your child have vomiting? If so, when does vomiting occur? (please circle)
During feeding After feeding Unrelated to feeding When upset

How often does vomiting occur? ____

How often does your child have a bowel movement? ____Times per day ____Times per week

Are stools usually (please circle): Watery Pasty Formed Runny

Has your child ever had a problem with ongoing constipation? _____Yes ____No

Does your child receive tube feedings (NG or G-tube)? _____Yes _____No

What is the schedule (include volume of each feeding and water flushes) __________

____

What rate is your child's tube-feed? ____

What formula is used for the tube feed?____

How is the formula prepared (if not ready to feed) ________________________________

Describe if problems are occurring ____

Does your child avoid any consistencies? If yes, circle all that apply:
Smooth Crunchy Chewy Soft Mixed/lumpy

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What problem(s) does your child have with feeding? (please circle)

Eats too fast	Eats too little	Messy eater	Skips meals
Eats too slow	Eats too much	Plays with food	Pocketing
Does not chew	Pushes food away	Leaves table	Cries or tantrums
Eats non-food items	Sneaks food	Refuses to swallow	Coughs
Spits food out	Refuses to open mouth	Drools	Vomits
Throws/drops food	Takes food from others	Grazing	Gags
Turns away from spoon		Other____________________________	
Picky eater (see below)			

If picky eater, what foods are accepted?____

What feeding techniques do you use with your child to get him/her to eat? (please circle)

Coax	Distraction	Limit foods	Threaten	Change meal schedule
Spank	Offer reward	Force feed	Ignore	Send to room/time out
Change foods offered		Praise	Other __________________________	

Where do you feed your child? (please circle)

Lap High chair/Booster seat Table/chair Other_________________

Does your child self-feed? ____Yes ____No

Are any special utensils used? If so, please specify. ________________________

What does your child drink from? (please circle)
Bottle Sippy cup Open cup Straw

Is it hard for you to tell if your child is hungry? ____ Yes ____ No

Does your child eat or have access to food between meals? ____ Yes _____No

Does your child's food intake vary? ____

Does your child eat better for one caregiver than other? ___Yes ____No

If yes, please specify the individual:_________________________________

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How long does a typical feeding/meal take? (please circle)

Less than 15 minutes 15-30 minutes 30-60 minutes More than 60 minutes

EATING STYLE:

How many meals are eaten outside the home per week: ______ Where: __________________

Favorite foods/drinks:____

Eats at the table with family: Always Never Sometimes

Eats in front of television: Always Never Sometimes

Any recent diet modifications?____

What time of day is your child most hungry: (please circle)

Morning Afternoon Evening Late Night

Does your child eat before going to bed: ___No ___Yes, what is eaten:___________________

Does your child wake up hungry at night? ___No ___ Yes, what is eaten:_________________

What does your child usually choose to drink: (please circle)

Soda- per day (ounces or cups):______________ Milk- per day (ounces or cups):____________
Juice- per day (ounces or cups):______________ Other:__________________________________
Water- per day (ounces or cups):______________

Who grocery shops? (please circle)
Mother Father Grandparent Step-parent Child Other:_________________________

Who prepares the meals? (please circle)
Mother Father Grandparent Step-parent Child Other:_________________________

What is frequently eaten for snacks? ____

If there is a weight problem, what has contributed to this? (Please circle)
Boredom Emotional eating Snacking No activity Eating out Portions
Other________________

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PAST MEDICAL HISTORY:

Birth History:

Weight:_________Length:________Full Term: **Yes** **No**

Which hospital? ____

If premature, at what week was child born: _______________

Any problems during pregnancy/delivery? ____

Please list any medical tests for feeding or past feeding therapy: (i.e. swallow study/upper GI/allergy testing) and note results of each____

____

Please detail any hospitalizations/surgeries/accidents/special medical treatments:

1. ____________________ date:___________ 4.____________________ date:_________

2.____________________ date:___________ 5.____________________ date:_________

3.____________________ date:___________ 6.____________________ date:________

DEVELOPMENTAL HISTORY: AT WHAT AGE DID YOUR CHILD:

Sit Up: ______ Walk: ______ Toilet Train: ______

IMMUNIZATIONS AND ALLERGIES:

Are Immunizations up to date? ____Yes _____ No

Allergies (food, medication etc.) ____

MEDICATIONS: Please list all medications within the last 3 months (include vitamins, health food remedies, etc.)____

____

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FAMILY HISTORY:

Who lives in the home with your child?____

Who is involved in your child's care? ____

Biological Parents (if known): Mother: Age: _____ Ht: _______Current Wt: _______

Father: Age: _____ Ht: _______Current Wt: _______

Siblings:	**Age**	**Male/Female**
Full – Half – Step	_______	M F
Full – Half – Step	_______	M F
Full – Half – Step	_______	M F
Full – Half – Step	_______	M F

Family history of (please circle)
***This includes extended family- grandparents, aunts, uncles, cousins**

Diabetes	Thyroid Problems	Obesity	Weight loss surgery
Peptic Ulcer	Reflux	Cancer	Gastric Ulcers
Gallbladder	Liver disease	ADHD	Seizure
Pancreatitis	Constipation	Anxiety	Depression
Arthritis	Hypertension	Mental Retardation	Learning problems
Stroke	Heart disease	Personality disorder	Infertility
Kidney disease	Schizophrenia	Low Blood Pressure	Allergies, Food
Eczema	Cystic Fibrosis	Celiac Disease	
Eating Disorder	Feeding Disorder	Irritable Bowel Syndrome	
Sickle Cell Trait or Disease		Thalassemia Trait or Disease	

Other ___________________________

SOCIAL HISTORY:

Caregiver marital status: (please circle)
Married Sustained relationship (not married) Divorced Separated Single Widowed

Does your child go to day care: ____Yes ____No **Sitter:** ____ Yes ____No

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What is the quality of your child's relations with other kids:

Poor Fair Average Excellent

Is your child happy: ____Yes ___No, please explain: ___________________________________

Has your child ever been bullied or teased? ___Yes ___No

Receiving any of these services? (please circle) OT PT Speech times per week:____

Which agency provides the service? ____ Infants and Toddlers ____School ___Private

IF IN SCHOOL:

Grade: ______**What school does your child attend**?______________________________

School performance: Poor Fair Average Excellent

Does your child have either an IEP: ___Yes ___No **or 504 plan**: ___Yes ___No

If yes, please detail:____

Do you have any concerns about your child's development or behavior? ___Yes ____ No

If yes, explain.____

Caregiver 1 highest level of education: _________________________
Caregiver 1 Occupation: ___________________ **number of hours worked/week:** _________
Caregiver 2 highest level of education: __________________________
Caregiver 2 Occupation:_____________________ **number of hours worked/week:** ________

Primary caregiver's work schedule: (please circle)
Weekdays Weekends Week nights

Any significant changes in the family in the past 6 months:____________________________

REVIEW OF SYSTEMS:

Has your child ever been treated for the following conditions? (please circle)
ADHD ODD Anxiety Depression Mental Health Conditions

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Does your child have any of these symptoms: (please circle)

Allergy	Bleeding Tendency	Headaches	Morning Headaches
Trouble breathing	Shortness of breath	Heavy breathing	Asthma
Snoring	Snores loudly	Mouth open(day)	Heartburn
Abdominal pain	Constipation	Diarrhea	Bedwetting
Joint problems	Tired in morning	Sleepy in school	Easily distracted
Difficulty organizing	Interrupts conversations	Wears glasses	Gagging
Trouble following directions	Vomiting	Frequent ear infections	Urinary problems

Has your child seen, or currently sees a mental health professional? ___Yes ___No

What does your child do for physical activity? (For example plays at playground, dances etc.)____
____

How much time each day does your child spend doing physical activities? _____________

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FOOD INTAKE LOG Fill out three days of food records, one sheet for each day. Under the column "Amount Consumed", do not use words like "pieces", "bites" or "sips". Instead use teaspoons, tablespoons, cups, or ounces. Under "Description", include the brand name of the food if it is a pre-made/packaged item.

Date & Day of Week:________________ Was child ill on this day? Y/N Vitamin/Mineral supplements taken: _________________________________G-Tube feedings – if applicable (name formula, feeding schedule, volume of each feeding, and water flushes):

____

____

Formula Recipe – if applicable (*example*: 6 scoops Enfamil Lipil powder + 10 ounces water):

____

Day's intake considered: □ Typical for Child □ More than Usual □ Less than Usual

____

DAY 1 **Time**	**Place food was consumed** (home, school, restaurant, etc)	**Food, Beverages** (Meals and Snacks)		**Amount Consumed**
		Food/Beverage Item	Description (include Brand name of food)	
Example 8 am	home	cereal	Cheerios	2 TBSP
		milk	2%	1 oz

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DAY 2 **Time**	**Place food was consumed** (home, school, restaurant, etc)	**Food, Beverages** (Meals and Snacks)		**Amount Consumed**
		Food/Beverage Item	Description (include Brand name of food)	

DAY 3 **Time**	**Place food was consumed** (home, school, restaurant, etc)	**Food, Beverages** (Meals and Snacks)		**Amount Consumed**
		Food/Beverage Item	Description (include Brand name of food)	

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Please return your completed form to MWPH.

Mail to: Mt. Washington Pediatric Hospital
Center for Nutritional Rehabilitation
1708 West Rogers Ave
Baltimore, MD 21209

Or fax to us: 410-578-2654

Call us at 410-578-5250 for the instructions to email this form using our secure messaging system.

If you chose to email this form to Mt. Washington Pediatric Hospital using unencrypted email, please sign below that you understand your child's personal and health information may be at risk if sent using an unsecured email system.

Include this consent with your form

____ _______________
Signature, parent/guardian Date