ST. FRANCIS
Capable Kids
a pediatric therapy center

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FEEDING PRE-EVALUATION PACKET

Thank you for taking the time to fill out this packet. The information you provide will help us to better plan your child's evaluation to meet his/her needs!

Your Name: _____ Relationship to Patient: _____

Child's Information			
Name:		Preferred Name:	
Date of Birth:		Age:	
Gender:			
Primary Language:		Secondary Language:	
Primary and Referring (If different) Physician:		Clinic Name:	
Clinic Location/Address:		Clinic Phone Number:	
Mother's Name:		Father's Name:	
DIAGNOSIS:			
Reason for Evaluation (concerns):			
Does your child require the services of an interpreter? If yes language _____		o YES	o NO
Is your child legally blind?		o YES	o NO
Does your child need assistance for hearing?		o YES	o NO
Is this visit the result of an accident or injury?		o YES	o NO
If you answered yes, please specify the date and place of injury and give a general description:		DATE: PLACE of INJURY: DESCRIPTION:	
What is your child's country of origin (optional)?			
What is your child's ethnic group (optional)		o Hispanic/Latino	o Non Hispanic or Latino
What is your child's race (optional)			
What is your child's religion (optional)			

Demographic Information		
Home Address:		
Parent Phone Numbers:	Primary Contact Name:	Secondary Contact Name:
	Cell #	Cell #
	Work#	Work #
	Home#	Home #

Insurance Information	
Who is the guarantor (person responsible for the bill)?	

PRIMARY INSURANCE:			
Name of Insurance Company			
Policy ID Number			
Group Account Number			
Eligibility/Benefits/ Customer Service Phone #			
Policy Holder Information			
Name		Date of Birth (Month/Day/Year):	
Relationship to patient			
Employer:		Employer Address:	
Employment Status:	o Full Time	o Part-Time	o Not Employed

SECONDARY INSURANCE (if applicable):			
Name of Insurance Company			
Policy ID Number			
Group Account Number			
Eligibility/Benefits/ Customer Service Phone Number			
Policy Holder Information			
Name		Date of Birth (Month/Day/Year)	
Relationship to patient			
Employer:		Employer Address:	
Employment Status:	o Full Time	o Part-Time	o Not Employed

Living Situation: *Please list the people who live at home with the patient*		
Name	Age	Relationship to Patient

Does your child require any special or adaptive equipment to access their environment? o Yes - If so, what? o No			
Does child attend day care? o Yes o No Name:	If yes, days/hours per week?	Does child attend school? o Yes o No	If yes, School Name and Grade

Pregnancy History: *Please comment on any "yes" answers*

What month did you begin prenatal care?			Please note if you had any issues/events during pregnancy including: chronic medical conditions, gynecological issues, accident/injury, toxin/drug exposure. Please note the month and any relevant details in the comments section.
	Yes	No	COMMENTS:
Any issues getting pregnant?			
Did you experience weight gain beyond expectation or weight loss during pregnancy?			
Any medications taken during pregnancy?			
Any complications with pregnancy?			
Was pregnancy full term?			

Birth History: *Please comment on any "yes" answers*

Issues with delivery?			Comment:
Cyanosis (turning blue)			
Jaundice			
Congenital Defects			
Required oxygen/transfusion/tube feeding after birth?			
Health problems / illnesses during first two weeks of life?			

Hospital (Name) and City/State:	Gestational age at time of delivery (# weeks/days early/late)
Birth Length:	Birth Weight:
Length of Labor (in hours):	Any type of labor stimulation used?
Any type of pain medication or anesthesia used during delivery?	What type of delivery (please circle)? Vaginal / Cesarean Section (elective) (emergency)
Any assistance during delivery: Forceps, Vacuum, other?	Presentation (please circle): Head / Face / Breech / Transverse
APGAR score _____1 minute _____ 5 minutes	If your child spent time in the Special Care Nursery or NICU please specify which and how long:

FAMILY MEDICAL : *Please answer each "Yes" or "No" question relating to your <u>child's BIOLOGICAL family members</u>. Please indicate how the family member is related to your child (for example: mother's uncle etc.).*

Question	*Yes*	*No*	*Relationship to Child*	*Comments or Additional information:*
Genetic Disorder				
Developmental Delay				
Diabetes				
Learning Disability				
Feeding Disorder				
Mental Health Issues				
Neurological Disease				
Physical Disability				
Immune System Compromise				

CHILD'S MEDICAL: *Please answer each "Yes" or "No" question relating to your child's medical history. Please explain any "Yes" answers in the comments section below.*

	Yes	No		Yes	No
Any Surgeries?			Any Allergies?		
Serious Injuries?			Reflux/Excessive Vomiting?		
Heart Problems? (Arrhythmias, surgeries, congenital issues)			Childhood Communicable Disease (Strep, Fifth's disease, Hand foot mouth, etc.)		
Respiratory Issues? (Chronic colds / infections / asthma / RSV)?			Chicken Pox/Mumps, Measles, Meningitis?		
Seizures?			Attention Issues?		
Diabetes?			Hearing Problems Ear infections/Hearing Aides/Tubes?		
Episodes of dehydration/constipation/diarrhea?			Issues with weight gain?		
Ingestion of toxins/poisons/ foreign objects?			Dental issues		
Pain? Headaches, back, limbs?			Vision Problems Glasses?		
Previous Therapy Services OT			Facility Name:		
ST			Date of Evaluation:		
PT			Dates of Treatment:		

COMMENTS:

MEDICATIONS: *Please list all of your child's medications and the additional information requested if possible. List additional on back of page.*

Medication	*Reason*	*Dosage*	*Start Date*

HOSPITALIZATIONS/SURGERIES: ***Please list any dates of hospitalization/surgery your child has had and the reasons.***	
Date: *Reason:*	*Date:* *Reason:*
Date: *Reason:*	*Date:* *Reason:*

PHYSICIANS/SPECIALISTS: *Please list any physicians or specialists that are involved in your child's care besides your primary physician listed above.*

Physician Name	*Facility/ Contact Number*	*Specialty*	*Date of Last Appointment/ Frequency of Appointments*

DEVELOPMENTAL HISTORY: *Please let us know how your child achieved these developmental milestones. Write N/A in comments if a particular category does not apply to your child for age or other reasons.*

Skill	**Early**	**On Time**	**Late**	**Not Achieved Yet**	**Comments**
Rolled Over Both Ways					
Sit Independently					
Crawl					
Pull to Stand/ Cruise					
Walk					
Run					
Jump with Both Feet					
Kick a Ball					
Stand on One Leg					
Ride a Tricycle					
Use finger and thumb to pick up a small object/food					
Feed self with utensils with minimal spillage					
Use a 3-point position on writing utensils					
Use a scissors					
Catch/Throw a Ball					
Follows Simple Directions					

Drink from open cup					
Transition to solid foods (puree/baby food)					
Transition to table foods					
Speak First Words					

NUTRITIONAL HISTORY ***List if your child had any difficulties in the following areas, and describe***				
ITEM	NO	YES	N/A	EXPLANATION
Suck/ swallow/ breathe pattern				
Latching on/Accepting the bottle				
Transition to table foods				
Transition to cup				
Use of feeding utensils				
Tolerating specific tastes and/or textures				
Developed independent appetite cycles (knows hunger and full feelings)				

Current Performance: *We'd like to know more about your child's feeding, Please answer the following questions.*

1. What are your child's accepted foods or categories of foods?

2. What are your child's biggest struggles with feeding (certain textures, difficulty chewing, difficulty sitting at table, etc.)?

3. Please describe your child's feeding schedule. (time of day, length of time, amount consumed, positioning)

- Times of day (every hour, or 1:30, 5:00, etc.):
- Length of time to consume a typical meal:
- Amount of food ingested per meal

- Positioning during feeding (high chair, etc.):
  Are their feet supported (please circle): Yes No

- Where (what room) does this child typically eat?

- Who feeds/eats with this child?

- Are there any strategies that you use to help your child with eating (playing music, TV/video, games, singing, etc.)

- Additional comments (Please include any major feeding/eating milestones or changes for your child- this may include changes in formula, initial acceptance and then refusal of foods, etc.): _

4. Please describe your feelings and concerns related to feeding for your child.

5. Are there any personal beliefs, restrictions, or routines about food/eating that we should be aware of?

6. What are your top 3 priorities for having this evaluation and possible treatment for your child's feeding needs?