Pediatric Feeding/Digestive Disorders Program

Screening Form

Instructions:

Dear Caregiver,

We received your name as someone whose child may benefit from services in the Feeding/Digestive Disorders Program. This form is designed to help us get information needed to pick the best type of assessment for your child. We understand that you may have already provided this information to many other people as you set up services for your child; however, putting it together here will help us make progress as fast as possible. We appreciate your time in putting together the information.

Please fill out this form including the three day food record and return it as soon as possible. We will call to **schedule** an evaluation, **after we have received this form**. Please, send it to:

Marcus Autism Center
Attention: Karen Chamberlain
Pediatric Feeding Disorders Program
1920 Briarcliff Road
Atlanta, GA 30329

Fax: 404-785-9041

For proper evaluation, please provide copies of the following items prior to your visit:

1. We are interested in reviewing results from evaluations related to your concerns with feeding/digestive issues, especially tests by a gastroenterologist or any swallowing studies. You may wish to contact your child's pediatrician to see if that office could send us copies of evaluation reports. Reports may be mailed or faxed to the location listed above.
2. Make sure you list height & weight on page # 4. Please, send a growth chart, if possible.
3. Be sure to complete the three day food record at the end of this from.

If you have any questions or need assistance please write or call the Pediatric Feeding Disorders Program, 404-785-9493

Thank you very much for your interest in the Pediatric Feeding Disorders Program.

BIOGRAPHICAL

Child's Name: _____ Sex: _____ Date of Birth: _____

Caregivers' Name(s): _____

Address: _____ City, State, Zip:_____

Email: _____ Telephone: _____

Child's Legal Guardian: _____

How did you learn about our program (who referred you)? _____

Has your child been seen before at the Marcus Autism Center: ____ Yes ____No

Name of person completing this form: _____ Today's Date: _____

Primary Reason for Referral (Please circle all that apply)

a. My child is feeding tube dependent and accepts little food by mouth
b. My child mostly get nutrition by drinking formula
c. My child has lost weight (_____ pounds)
d. My child only eats certain food/ is extremely picky
e. My child has poor self-feeding skills
f. My child eats too much or is gaining weight
g. Other: _____

When did these problems begin? _____ Have these problems been ☐ continuous or ☐ off-and-on?

In your opinion why does your child have these problems? _____

_____

FEEDING DIFFICULTY

My child has the following behaviors that are problems at meals:

	Head turning		Aggression
	Pushing away the spoon		Disruption
	Crying		Making negative statements
	Screaming		Vomiting
	Leaving the table		Other:
	Throwing food		

What do you do when your child will not eat/drink? _____
_____

Have you identified any methods that work for managing mealtime behaviors? If so, please describe:
_____.

Who else has tried to help your child with FEEDING issues?

Please list your child's past and current therapies for feeding difficulties.

Name:_____ Affiliation:_____

Phone:_____ Address: _____

Dates of Service:_____ Discipline: Speech OT Physical Therapy Other: _____

What did they recommend?: _____

Did the therapy help?_____ If yes, how?_____
==========

Name:_____ Affiliation:_____

Phone:_____ Address: _____

Dates of Service:_____ Discipline: Speech OT Physical Therapy Other: _____

What did they recommend?: _____

Did the therapy help?_____ If yes, how?_____
==========

Name:_____ Affiliation:_____

Phone:_____ Address: _____

Dates of Service:_____ Discipline: Speech OT Physical Therapy Other: _____

What did they recommend?: _____

Did the therapy help?_____ If yes, how?_____
==========

MEDICAL PROVIDERS

Name of Primary Care Physician (pediatrician): _____Affiliation: _____

Address: _____

Telephone: _____

Name of Gastroenterologist (GI doctor): _____ Affiliation: _____

Telephone: _____

Name of psychologist/psychiatrist/other mental health worker: _____

Affiliation: _____ Telephone: _____

Please list any other physicians who are treating your child (attach separate sheet if needed):

Name: _____ Specialty: _____

Telephone: _____

Name: _____ Specialty: _____

Telephone: _____

SCHOOL/DAY CARE

School Name:_____ Teacher Name:_____

Grade Level: _____ List any special education services: _____

Address:_____ Phone:_____

Has your child's school/day care addressed your child's feeding difficulties? _____

If yes, how?_____

Was this effective?_____ How?_____

Has your child been missing school? Yes / No Dropping school activities? Yes / No

MEDICAL INFORMATION

Growth & Nutrition:

Current Height: _____ Current Weight: _____

Has a medical provider ever expressed concerns regarding your child's weight and growth? ___ Yes ___ No

If yes, please explain _____

During infancy, was child fed by bottle ____, breast ____, combination _____

At what age were solids introduced? _____

List any foods usually accepted:

fruits _____
meats _____
breads, cereals _____
vegetables _____
dairy products _____
sweets _____

Do any foods cause physical problems when eaten? __ No __ Yes, _____

Describe any special diet that you adhere to for your child (Kosher, gluten-free, etc.)

_____

Please indicate your child's typical mealtime schedule and sample meals. Give approximate amounts.

	Sample/Typical Meal	Approximate Mealtime
Breakfast -		
AM Snack -		
Lunch-		
PM Snack -		
Dinner-		
Snack -		

Describe the sequence in which food is offered to your child (e.g., liquids always first, etc.):

_____

Does your child's food habits and preferences match the family's? ____ Yes ____ No

Does your child eat little meals and snacks throughout the day? ____ Yes ____ No

Your child's appetite is best described as (circle one):

poor fair good excellent eats too much

How long does it take for your child to complete a meal? (circle one)
less than 10 minutes 10-20 minutes 20-30 minutes over 60 minutes

How does your child show hunger? _____

Bowel Habits:

Frequency of Bowel Movements: _____ times per (circle one): day week

Consistency: hard soft loose watery

Is your child toilet trained? ____ Yes ____ No

Are there any concerns with toileting? ____ No ____ Yes: _____

Pregnancy:
Pregnancy Term: ___ Preemie: _____ weeks ___Full-term

Pregnancy Complications: ___None ___Gestational Diabetes ___Anoxia ___Pre-eclampsia

Other Complications: _____

Development:

Age when your child could do the following:

Behavior	Age	Behavior	Age	Behavior	Age
Smile		Roll over		Sit alone	
Stand alone		Walk		Mimic adults	
Say single word		Talk in sentences		Can follow instructions	
Urinate in toilet		Have BM in toilet		Get dressed	

Estimated **mental functioning** (circle one):

Above Average	Normal intelligence	Mild Mental Delay	Moderate Mental Delay	Severe or Profound Mental Delay

This estimated mental functioning is from (circle one): School testing Psychologist testing My best guess

Please list your child's current medications.

Medication	Dose	Prescribing Doctor

Breathing Tubes:

Type of Tube	Dates in use
Nasal canula	
Tracheotomy	

Feeding Tubes:

Type of Tube	Dates	Formula name	Amount (cc)	% of daily intake
Nasogastric (NG-tube)				
Gastrostomy (G-tube)				
Jejunostomy (J-tube)				
Other:				

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**
ADHD / Hyperactivity			Abdominal pain (this may be expressed as **increase** in behaviors like pressing on the abdomen, self-injurious behavior, and/or aggression)		
Asthma / Wheezing			Abdominal pain during meals		
Cancer- type _____			Abdominal pain after eating		
Eczema			Abdominal pain in the middle of the night		
Heart Murmur			Abdominal pain better with stooling		
Neurologic Disorder			Pain in back/shoulder		
Pneumonia			Vomiting bile (bright green)		
Strep throat			Vomiting frequently		
Food Allergies*			Vomiting bright red blood or brown (like coffee grounds)		
Environmental Allergies*			Episodes of vomiting which start quickly, last for at least >2 hours but sometimes days, and then resolve		
Autism			Gastroesophageal Reflux		
Depression			Spits up in sleep		
Headaches			Night time cough		
HIV/AIDS			Difficulty sleeping		
Otitis Media (ear infections)			Hoarseness		
Seizures			Recurrent congestion		
Varicella (chicken pox)			Chest pain/heartburn		
Anxiety			Chronic nausea		
Bleeding Disorder			Feels like food "gets stuck"		
Diabetes Mellitus (type 1 or 2)			Difficulty swallowing-		
Hearing Loss			Eosinophilic esophagitis		
Jaundice / yellow skin or eyes			Constipation		
Psychiatric Disorder- _____			Strains to hold stool in		
Sickle Cell Anemia			Painful bowel movements		
Vision problems			Passes a lot of gas (more than other family members)		
Heart problems/defects- _____			Abdominal bloating/distension		
Cerebral palsy			Foul-smelling stools (worse than other family members)		
apraxia (oral or verbal)*			Diarrhea		
Dyspraxia/developmental coordination disorder/clumsy child syndrome*			Pale stools (grey, white or very light)		
Hypotonia/low muscle tone*			Bright red blood in stools		
Sensory integration disorder (Sensory issues, high or low pain threshold, doesn't sense pain like other children)			Black sticky stools (like tar)		
Neurologic disorder-_____			Fevers (not otherwise explained)		

Anemia			Rashes		
Frequent bleeding (including from gums/teeth)			Joint swelling and/or pain (not explained by obvious trauma)		
Easy bruising			Mouth sores		
Enlarged adenoids and/or tonsils			Weight loss		
Snores			"Failure to thrive" (doctors are worried about poor growth in height and/r weight on growth charts)		
Aspiration pneumonia			Fatigue/loss of energy/ excessive sleepiness		
Bronchopulmonary dysplasia			Obesity / overweight		
Celiac disease			Elevated liver tests		
Stomach ulcers			Endocrine disorder- _____		
Inflammatory bowel disease (Ulcerative colitis/Crohn's disease)			Seems to get much more ill from common illnesses than other family members (e.g requiring emergency room visits)		
Pulmonary disorder-			Metabolic or genetic disease- _____		

Other medical diagnoses: _____

*****PLEASE, BRING TEST RESULTS/REPORTS TO YOUR APPOINTMENT.*****

Hospitalizations and procedures (attach extra sheet if needed):

Month/Year	Name of Procedure or Reason for Hospital Admission	Result
	Swallow study (MBS / OPMS)	
	Endoscopy	
	Gastric Emptying	
	pH probe	
	Upper GI	
	Allergy Skin Testing	
	Allergy Blood Test	
	Colonoscopy	
	Blood transfusion	

Immunizations are up-to-date? Yes/No If no, why?_____

CURRENT FEEDING PRACTICES

My child eats: ___alone or ___ with the family?

Meals typically last: _____ minutes # Meals per day: _____ # Snacks per day: _____

Food texture/consistency. Please mark how often they are eaten & how willing your child is to eat them.

	How often?					How Willing?			
	Never	1-2 times/year	Monthly	Weekly	Daily	Totally Refuses	With Prodding	Willing	Favorite
liquids/soups									
strained baby food									
stage 3 baby food									
creamy foods (pudding, yogurt)									
Pureed table food									
mashed table food									
chopped table food									
regular table food									
crisp foods (crackers, chips, toast)									
chewy foods (meat)									
crunchy foods (carrots, celery)									

Current Mealtime Skills (Check all that apply.)

		Currently Uses	Needs help	Would like to be able	Causes Problem
SEATING	Regular chair @ table				
	Booster seat				
	High chair				
	Adaptive chair (describe):				
	Other (please specify)				
FEEDING UTENSILS	Spoon				
	Fork				
	Knife				
	Finger-feeds				
DRINKING UTENSILS	Baby bottle (type):				
	Sippy cup				
	Straw				
	Open cup				

ORAL MOTOR STATUS

Check any of these **problems** that occur for your child:

	Drooling		Vomiting/Rumination
	Continuous sucking; poor sucking		Teeth Grinding

	Biting (independently biting off pieces of food)		Coughing
	Tongue control (tongue thrust, poor mobility)		Gagging
	Swallowing		Profuse perspiration (diaphoresis)
	Lip control (keeping his/her mouth closed)		Aspiration (wet-sounding or "gurgly" voice)
	Chewing (for children over 12 months)		Packing food in mouth (holding in cheek, under tongue)
	Hypersensitivity to food textures, temperature, spoon		Overstuffing (too much in mouth at a time)
	Other:		

OTHER BEHAVIORS AND HABITS

Sleep:

What time does your child go to bed?: _____ Wake up?: _____ Nap?: _____

Does your child have problems going to sleep at night? ____ No ____ Yes
If yes, explain: _____

Social relations:

Does your child appear to enjoy social interaction? ____ Yes ____ No

Does your child have problems being away from you (babysitter, bedtime)? ____ Yes ____ No
If yes, explain: _____

Does your child require special supervision (for example, to avoid self-injury)? ____ Yes ____ No
If yes, explain: _____

Please, list behaviors that cause problems for your child more than others her/his age? (e.g., tantrums, aggression)?

_____

Family Information:

Who lives with this child ? (relationship & age) _____

Does anyone smoke in the home? __ Yes __ No

Recent travel or camping? Y / N Where? _____

Exposure to creek, lake, or well water? Y / N Where? _____

What animals is the child around? _____

Mother / caregiver occupation: _____

Father / caregiver occupation: _____

My child's health insurance provider(s) is/are: _____

Check problems that occur in family members other than patient and list the affected family member: Use the following abbreviations: M- mother, F- father, B - brother, S – sister, GM – grandmother, GF- grandfather, A –

aunt, U – uncle, C – cousin

☐ Constipation	☐ Food allergies	☐ Chronic vomiting
☐ Spastic colon	☐ Asthma	☐ Hiatal hernia
☐ Abdominal pain	☐ Eczema	☐ Seizures/epilepsy
☐ Swings in bowel habits	☐ Migraines	☐ Yellow skin/jaundice
☐ Chronic loose stools	☐ Muscle disease	☐ Liver disease
☐ Irritable bowel syndrome	☐ Neurological problems	☐ Thyroid disease
☐ Blood in stools	☐ Arthritis	☐ Heart attack before 50
☐ Ulcerative colitis	☐ Psychiatric problems	☐ Cystic fibrosis
☐ Crohn's disease	☐ SIDS/childhood deaths	☐ Cancer
☐ Intestinal polyps	☐ Tuberculosis	☐ Celiac disease
☐ Stomach ulcers	☐ Sickle cell anemia	☐ Gallbladder disease

What else would you like for us to know?

_____

_____

THREE DAY FOOD RECORD

Instructions: Record all food and fluid consumed during the next three days. Please be as specific as possible to ensure accuracy of the analysis. Record the amount eaten in either volume (tbsp, cup) or weight (g, oz) measurements. Include brand names and methods of preparation when appropriate. *If your child is on a tube feeding, please specify if the food/formula was consumed by mouth or through the tube.*

Note: If an altered texture is being prepared i.e., pureed table food or wet ground, the yield of the "mixture" should be recorded as well as the amount consumed.

For example:

Date:	**Food Item:**	**Yield (total serving):**	**Amount Eaten:**
4/13/12	pureed chicken nuggets (4 nuggets, 1/2 c whole milk)	1 cup	1/3 cup
	carrots, canned		3 tbs.
	red grapes		25 ea.
	Kraft shells and cheese		1/2 cup
	Homemade Mango Shake (1 c mango, 1 1/2 c Wh. Milk)	2 cup	3/4 cup
	Tube feeding: Pediasure		480 cc

Date:	Food Item	Yield (Total Serving):	Amount Eaten:

Date:	Food Item	Yield (Total Serving):	Amount Eaten:

Date:	Food Item	Yield (Total Serving):	Amount Eaten: