CHILDREN'S HOSPITAL OF RICHMOND AT VCU

Feeding Intake Questionaire

Name_____

MR# _____

PERSONAL INFORMATION

Patient Name:		Date of Birth/Age:	
Parent(s) Name(s):		Town/City/State of Residence:	
Referred By:			
Primary Care Physician:		Other Physicians:	
Telephone # of PCP:	( )	Telephone #:	( )
Address of PCP:		Address:	
Other Physicians:		Other Physicians:	
Telephone #:	( )	Telephone #:	( )
Address:		Address:	
Other Physicians:		Other Physicians:	
Telephone #:	( )	Telephone #:	( )
Address:		Address:	

FEEDING INFORMATION

Chief Complaint:
Current Diet (include daily caloric intake and recommended daily calories, if relevant):
Nasogastric or Gastrostomy Tube - describe feeding formula and schedule:
Current Liquid Intake (in 24 hours): Water _____ Formula _____ Juice _____ Other _____
Preferred Foods:
Non-preferred Foods:
Food Allergies:
Setting in which child eats:
Previous Evaluations:

CONTINUED ON BACK

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PAST MEDICAL HISTORY

Dates(s) / Onset	Completed Tests/Surgeries/Hospitalizations	Comments

Last Upper GI, Barium Swallow, and Gastric Emptying with results:

MEDICAL INFORMATION

DIAGNOSES:

- ☐ Cerebral Palsy
- ☐ Gastroesophageal Reflux
- ☐ Failure to Thrive
- ☐ Developmental Delay
- ☐ Oral Aversion
- ☐ Other (please describe)

Allergies to Medications and Foods (list all):

Medications:

FAMILY MEDICAL HISTORY

Has anyone in your family ever been diasgnosed with or treated for any of the following?

YES	NO	RELATIVE	ILLNESS/DISEASE
☐	☐		Reflux Disease
☐	☐		Scoliosis or other musculoskeletal abnormalities
☐	☐		Allergies to food or medications
☐	☐		Other:
☐	☐		Other:

BIRTH HISTORY

Length of Pregnancy: _____

Birth Weight: _____

Birth Height: _____

Type of Delivery: _____

Complications (explain): _____

_____

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SOCIAL HISTORY

Who lives in the house?
A child care provider?
School Status/Early Intervention:

CURRENT MEDICAL CONDITIONS

YES	NO	Is the child experiencing any of the following?:	If yes to any of the following questions, please describe
☐	☐	Recurrent ear infections	
☐	☐	Recurrent colds or sinus infections	
☐	☐	Recurrent ulcers in the mouth	
☐	☐	Frequent choking or gagging	
☐	☐	Chronic or recurrent cough	
☐	☐	Pneumonia	
☐	☐	Wheezing	
☐	☐	Environmental allergies	
☐	☐	Heart murmur	
☐	☐	Congenital heart disease	
☐	☐	Appetite changed ☐ Increase ☐ Decrease	
☐	☐	Nausea ☐ or Vomiting ☐	
☐	☐	Frequent spitting up or regurgitation	
☐	☐	Constipation	

CONTINUED ON BACK

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Name_____

MR# _____

CURRENT MEDICAL CONDITIONS (Continued)

YES	NO	Is the child experiencing any of the following?:	If yes to any of the following questions, please describe
☐	☐	Diarrhea	
☐	☐	Abdominal pain	
☐	☐	Weight loss	
☐	☐	Food allergies	
☐	☐	Urinary tract infections	
☐	☐	Decrease in urination	
☐	☐	Increase in urination	
☐	☐	Spasticity	
☐	☐	Hypotonia	
☐	☐	Delay in motor skills	
☐	☐	Delay in speech	
☐	☐	Sensory issues	
☐	☐	Therapy	
☐	☐	Fractures or broken bones	
☐	☐	Use of splints	
☐	☐	Scoliosis	
☐	☐	Skin rash	
☐	☐	Skin breakdown	
☐	☐	Seizures	

Signature:_____ Date:_____

(Person completing form)