Child's Name: _____ Therapedia #:_____

Therapedia™, LLC
Exceptional therapy for children.

Thank you for choosing Therapedia! Please fill out the following information so we can best treat your child. On the day of the evaluation, please bring:

1) All filled out forms

2) Be prepared to feed your child – whether formula or breast milk in a bottle and/or cup that you are currently using

3) One to two foods that have been introduced and that they are eating well

4) A pacifier if your child takes one

5) Two-day log of how many ounces at each feeding and all foods presented and with responses. Please include frequency of peeing and pooping

6) Please do not feed your child right before the evaluation. We will need to see them eating.

Current Feeding: Main concern(s): _____

_____

Age problem started: _____

Feeding Problems:

___ volume limiting ___ picky ___ refusal ___ gagging ___ closes mouth/turns away
___ no signs of hunger ___ crying/irritable with meals ___ grazes ___ vomits ___ holds/pockets food
___ spits food out __Other: _____

Appetite: ___Poor ___Fair ___Good ___Varies from day to day
Best time of day to eat _____; Average length of time for a meal: _____

Other areas:
Do you have problems brushing his/her teeth? ____ yes ____no
Does he/she bring toys or hand to mouth? ____yes ____no As a baby? ___ yes ___no

Nutrition/ Growth History: Weight_____ Height_____ Weight for Height_____
Concerns for weight gain or growth? ___ yes ___no Loses weight when sick? ___ yes ___no
Allergies: Yes **Food** :_____
Yes Other: _____

Gastrointestinal History

Past	**Current**	
____	____	Frequent spitting up after meals or in between feedings
____	____	Frequent hiccups

____ ____ Frequently shows signs of hunger but only feeds a few minutes because of discomfort
____ ____ Difficulty swallowing
____ ____ Arching the back during feeding
____ ____ Irritability, persistent crying

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____ ____ Fussing after feeding
____ ____ Signs of abdominal pain: drawing up legs, arching back
____ ____ Sour burps or bad breath
____ ____ Waking from sound sleep with screaming and/or writhing
____ ____ Poor weight gain, poor growth
____ ____ Wheezing or excessive coughing
____ ____ Resisting all feedings or solid foods
____ ____ Reflux
____ ____ G-tube or nasogastric tube feedings (underline one or both)
____ ____ Nissen fundoplication
____ ____ Constipation
____ ____ Diarrhea
____ ____ Inconsistent stooling

Other Symptoms:
___ vomits/spits up (how often _____); ___ retching, ___ gagging, ___ pain,
___drooling, ___ bad breath, ___ sleep problems, ___ gassy, ___ feeding problems

Tests: (please write date of test, and results below)
Upper Gastrointestinal (UGI): _____ pH probe _____gastric emptying _____
Swallow Study: _____Endoscopy _____
Results:_____
_____

G-Tube Feedings:
Formula: _____ Schedule:(___ continuous ___ bolus ___ combination)
Day Schedule:(_____cc over ____ minutes/hours); Night Schedule:(_____cc over _____ minutes/hours)

Ear Nose Throat/ Pulmonary History:
Yes History of ear infections
Yes History of snoring
Yes Tonsils removed Yes Adenoids removed
Yes History of pneumonia, bronchitis, asthma, RAD X Yes
Yes History of congestion in AM _____, after meals _____, or anytime_____
Other:_____

Parent’s Signature

Date