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