SPAULDING™
EILEEN M. WARD
OUTPATIENT CENTER
for Children
SANDWICH

PATIENT IDENTIFICATION AREA

NUTRITION CASE HISTORY / INTERVIEW FORM
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NAME: _____ **AGE:** _____ **DOB:** _____

Why is your child being seen for a nutrition evaluation? _____

_____

Has your child ever seen a dietitian? _____ When? _____ Where? _____

MEDICAL HISTORY:

Primary Medical Diagnosis: _____

Past Medical History: _____

_____

Primary Care Physician: _____ Phone Number: _____

Has your child had any surgeries? ☐ No ☐ Yes If Yes, please list the dates: _____

_____

Has your child ever been hospitalized? ☐ No ☐ Yes If Yes, please list reason(s) and dates(s):

_____

_____

Is your child on any medication? ☐ No ☐ Yes If Yes, please list: _____

_____

Does your child have any allergies (food or otherwise)? ☐ No ☐ Yes If Yes, please list: _____

_____

Does your child take vitamin or mineral supplements? ☐ No ☐ Yes If Yes, please list: _____

_____

Pain: Location: _____ Rating: _____

BIRTH HISTORY:

Weight of your child at birth: _____

Was your child full-term? ☐ No ☐ Yes If No, how many weeks gestation? _____

Were there any problems during pregnancy? ☐ No ☐ Yes If Yes, please describe: _____

_____

Were there any problems immediately after birth? ☐ No ☐ Yes If Yes, please describe: _____

_____

How much does your child currently weigh? _____ Date of last weight: _____

My child is in:

- ☐ Daycare (name) _____
- ☐ Early Intervention (name) _____
- ☐ Pre-school (name) _____
- ☐ Head Start (name) _____
- ☐ Regular/typical class, specify grade level _____
- ☐ Regular/typical class with special education resource, grade level _____
- ☐ Full-time special education classroom _____
- ☐ Other (specify) _____

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Does your child receive any of the following services:

Service	Yes	No	Where?	How often?
Speech Therapy				
Occupational Therapy				
Physical Therapy				
Counseling/Behavior Therapy				
Visiting Nurses				
Other				

What physical activities is your child involved in and what amount of time per day does he/she participate (i.e., playing outside, team sports, dance, karate) _____

_____

GASTROINTESTINAL:

How often does your child have a bowel movement? _____

If applicable, how many wet diapers a day does your child have? _____

Does your child have problems with the following:

☐ Colic ☐ Diarrhea ☐ Constipation ☐ Vomiting ☐ Re□ux

If yes to any, please describe: _____

_____

_____

Has he/she been treated for growth problems? ☐ No ☐ Yes If Yes, please describe: _____

_____

FEEDING HISTORY:

Was your child breast fed? ☐ No ☐ Yes If Yes, how long? _____

Were there any problems with this (e.g., poor suck, slow to feed)? _____

_____

When was your child □rst given a bottle? _____

Were there any problems with this (e.g., poor suck, slow to feed)? ☐ No ☐ Yes If Yes, please describe: _____

_____

_____

If formula fed, what kind of formula was used? _____

When was your child weaned from bottle/breast? _____

When did your child start to eat solid foods? _____

Were there any problems with this? ☐ No ☐ Yes If Yes, please describe _____

_____

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Does your child exhibit any of the following behaviors:

- ☐ Crying
- ☐ Vomiting
- ☐ Coughing
- ☐ Gagging
- ☐ Choking
- ☐ Refusing to eat
- ☐ Getting down from the table during meal
- ☐ Holding food in his/her mouth
- ☐ Spitting food out of his/her mouth
- ☐ Regurgitating food

Does your child drink nutrition supplements by mouth (i.e., Pediasure, Boost Kid Essentials, Carnation Essentials, Elecare, Neocate, etc.) _____

Does your child receive supplemental (tube or parental) feeding? ☐ No ☐ Yes

If Yes, please answer the following:

NG: _____ TPN: _____ PN: _____

PEG: _____ PEJ: _____

Name of formula: _____ Rate: _____

Total Volume Amount: _____

Bolus (given via syringe several times a day): _____

Continuous (connected to pump): _____

CURRENT FEEDING / DRINKING SKILLS:

How many times a day does your child eat? (please specify) Meals: _____ Snacks: _____

How long does each meal take? _____

Approximately how much liquid does your child drink per day? _____

Does your child drink juice? ☐ No ☐ Yes

Is the juice given ☐ before ☐ during ☐ after a meal?

Does your child participate in tooth brushing? ☐ No ☐ Yes

Describe your tooth brushing routine: _____

What consistency of foods does your child eat?

- ☐ Regular liquids
- ☐ Thickened liquids
- ☐ Baby cereal
- ☐ Stage 1 baby foods (smooth)
- ☐ Stage 2 baby foods (semi-chunky)
- ☐ Stage 3 baby foods (chunky)
- ☐ Mashed table food
- ☐ Regular table food

How is liquid presented?

- ☐ Bottle _____
  Type of nipple _____
- ☐ Breast
- ☐ Cup
  - ☐ Spout
  - ☐ Lid with no spout
  - ☐ Cut-out cup

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Please tell us about your child's current feeding skills:

a. Finger feeding? ☐ No ☐ Yes
   If yes, how well? ☐ Beginning ☐ Partially successful ☐ Completely successful
b. Uses a spoon and/or fork? ☐ No ☐ Yes
   If yes, how well? ☐ Beginning ☐ Partially successful ☐ Completely successful
c. Breast-feeding? ☐ No ☐ Yes
   If yes, how well? _____

EATING ENVIRONMENT: ***(Please answer the following if your child is 5 years old or younger)***

Who feeds your child? (check all that apply) ☐ Mother ☐ Father ☐ Sibling ☐ Teacher
☐ Grandparent ☐ Daycare provider ☐ Other (please specify) _____

Who else is present for meals? _____

In what location of the house is your child fed?

☐ Kitchen ☐ Dining room ☐ Living Room ☐ Walking around
☐ Other _____

How is your child positioned when eating/drinking during meal/snack times?

☐ Infant seat ☐ Chair at table
☐ Child stands ☐ Child wanders around
☐ On caretakers lap ☐ In front of TV
☐ Highchair ☐ Held in arms
☐ Booster seat ☐ Sitting on the □oor
☐ Other _____

At what other locations does your child eat/drink?

☐ Daycare ☐ School ☐ Other relative's/friend's home ☐ In the car

Does your child eat (please check): ☐ more ☐ less ☐ same ☐ different foods when he/she is at
☐ day care ☐ babysitter's ☐ grandparent's ☐ other? (Please check and describe) _____

_____

_____

OTHER:

Do you have any speci□c questions you want to have answered at this visit? _____

_____

_____

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Screening for Abuse and Neglect:

Do you suspect your child has been physically, sexually, or emotionally abused? ☐ No ☐ Yes

May we audio tape your child's nutrition evaluation if needed? ☐ No ☐ Yes

May we videotape the evaluation and/or treatment sessions if needed? ☐ No ☐ Yes

*****Please attach any other information or comments that might be helpful along with any** reports/notes regarding your child's testing and/or previous therapy.***

Please sign below to con□rm that:

a) The above information is accurate to the best of your knowledge.

b) You have been given a copy of the policies of Spaulding Rehabilitation Hospital Cape Cod Outpatient Program (available at registration).

c) You agree to notify this facility with any changes to your child's status as a patient at Spaulding Rehabilitation Hospital Cape Cod Outpatient Program.

Person completing form: _____

Caregiver Signature	**Date**	**Time**	**Therapist Signature**	**Date**	**Time**
_____	_____	_____	_____	_____	_____