



Pediatric Intake Form- Infant Patient Questionnaire (0-12 Months)

The more information you provide, the better our therapist's can serve your child

Name:	Date of birth:	Age:
Reason for evaluation:	Referring provider (Name & profession	Childcare/day care set up:
Diagnosis:	Pediatrician:	Child lives with (Parents, siblings, etc):

Caregiver A Name: Relation:	Profession:	Phone number: Email:
Caregiver B Name: Relation:	Profession:	Phone number: Email:

Birth History

Delivery (vaginal/c-section):	Weeks gestation & weight at birth (ex- 33 weeks; 3 lbs, 4 oz):	Hospital: Days spent in hospital:
Pregnancy complications (pre-eclampsia, gestational diabetes, etc):		Birth complications (e.g. need oxygen, fetal distress, NICU, emergency c-section, jaundice, etc):
Additional information regarding pregnancy/ birth:		Use of forceps/vacuum in delivery:



Medical History/Status

Surgical history:	Hospitalization history:	Hearing assessment (date & status): Vision assessment (date & status):
Medications/supplements:	Allergies:	Tongue, lip or buccal tie release (Date & provider):

Mark ALL which apply					
Mouth breathes	Sleeps with open mouth	Reflux	Gas	GI discomfort	SnORES
Frequent congestion	Frequent cold	P-E tubes	Tonsil removal	Adenoid removal	Covid-19
History of bronchitis	History of sinusitis	Seizures	Heart problem	Seen ENT	Seasonal allergies
Hearing loss	High fever	Measles	NG/G Tube	Tracheomalacia	Cleft Lip/Palate
Recent Surgery	Difficulty Breathing		Other:		

Parent Observations/Behavioral History

Mark ALL which apply				
Poor sleep	Dislikes touch	Prefers Movement	Needs to be held/swaddled	Fussiness
Sensitive to sounds	Likes routine	Movement to calm down	Doesn't sleep well through the night	Clinginess
Easily upset	Doesn't notice noise	Likes touch	Fussiness	Dislikes movement
Head-banging	Separates from caregivers	Shy	Hyperactive	Lethargy
Seems content not to move	Dislikes changes in position (Laying down, picking up)	Sad	Anxious	Nervous
Wets bed	Destructive	Aggressive	Flapping	Poor concentration
Perseverates	Nightmares/terror	Other:		



Motor Milestones

Milestone	No	Yes (what age did they start)	
Rolling	Belly→ back	<i>To right & left?</i>	
	Back→ belly	<i>To right & left?</i>	
Sits independently			
Crawls		<i>Army or hands and knees</i>	
Walks			
Jumps (2 feet)			
Holds toy in hands			
Bangs toys together			
Mark ALL which apply			
Trouble changing surfaces	Trouble with stairs	Difficulty with grasp	Difficulty using utensils
Clumsy	Falls often	Trips easily	Other:

Feeding History- Breast

Mark ALL which apply				
Latched immediately following birth	Difficulty latching from the start, but figured it out	Difficulty latching from the start, was unsuccessful with breastfeeding	Uses/used finger feeder	Uses/used nipple shield
Uses/used syringe	Uses/used SNS	Does not breastfeed/no goal to breastfeed	Frequent spitting up/Reflux	Gas/Hiccups/Burping
Drooling/loss of fluid	Painful breastfeeding	Out of breath when feeding	Noisy eater	Other:



Feeding History- Bottle

Any bottle systems attempted and/or overt preferences for nipples/brands:	
What nipple is your child currently on?	
Any supplementation with formula? How much & how long?	
Additional information regarding bottle/breastfeeding journey:	
Any history of a MBSS and aspiration/penetration:	
Any history of thickening liquids:	
Any history of clefts, tracheomalacia or structural abnormalities:	

Feeding History- Solids

	No	Yes (What age did it start/comments)
Eats cut up table foods		
Drinks from a straw cup		
Drinks from an open cup		
Independently uses fork/spoon		
Eats a variety of textures/kinds of food (purees, soft foods, crunchy foods, meats, raw vegetables, fruit, etc.)		



Feeding Observations

Mark ALL which apply				
Out of breath while eating/drinking	Low volume of food	Finger sucking	Coughs/chokes	Low appetite
Excessive drooling	Noisy eater	Lip sucking	Reflux	Hiccups after eating
Suck blisters	Spillage/anterior loss	Hypersensitive gag reflex	Brings hands to mouth	Clenching/grinding teeth
Takes small bites	Eats <10 foods	Lip licking	Messy eater	Eats <20 foods
Burps often	Eats too slow	Poor intake	Refuses to open mouth	Refuses to eat
Turning head away from foods	Vomiting	Texture preference	Eats too fast	Nasal regurgitation
Stuffs mouth	Wet/vocal quality after eating	Arches back	Getting down from the table	Spits out food
Spillage of food/liquid	Throwing food/objects	Flavor preference	Crying	Holding food in their mouth
Takes large bites	Nail biting	Lip biting	Mouths/chews objects	Temperature preferences
Difficulty chewing	Extended paci use	Extended sippy cup use	Other:	

Where does your child sit during meals:					
Infant seat	Caregiver's arms/lap	Wanders	Crib	Highchair	Car Seat
Regular Chair	Bed	Booster seat	Stands	Sofa	Other:



Social History

	No	Yes (What age did it start/comments)
My child prefers to play alone		
List favorite toys, movies, or TV shows		

Parents Goals

What are you hoping to gain from feeding therapy?

Providers/Specialist

Pediatrician

Contact: May I contact this provider? ___Yes ___no

Lactation Consultant

Contact: May I contact this provider? ___Yes ___no

Craniosacral

Contact: May I contact this provider? ___Yes ___no

Chiropractor

Contact: May I contact this provider? ___Yes ___no

GI

Neurologist

Post NICU Team (New Hanover and ECU have one)

Hospital Based Feeding Team (ie. Nunlee Clinic)

Signature for Verification: _____ **Date:** _____