Dear Caregiver:

PLEASE READ THIS LETTER.

Thank you for your interest in the Pediatric Feeding Disorders Program. We will schedule an evaluation for your child when we receive your information.

You must send the following information BEFORE we will schedule your child's evaluation. *We will not schedule your appointment if the information is incomplete.*

	A completed copy of this form. *We will will cancel your appointment if the form is incomplete.*
	A record of everything your child eats and drinks for 3 days
	Notes from at least the last four visits to your child's primary care physician.
	A complete and up-to-date growth chart with your child's weight, height, and BMI.
	Results of any medical tests related to your child's feeding disorder (e.g., swallow study, pH probe).
	Records of previous and current therapy for your child's feeding disorder.
	Notes from your child's specialist(s) physician if the child's medical condition affects his or her feeding disorder.

Please save your completed electronic form as a PDF file (e.g., JaneDoe.PDF) and email it to me. Sending us an emailed electronic copy of this form will make your child's evaluation more efficient. Please contact me if you have any questions or need assistance. My contact information is below. Thank you very much for your interest in the Pediatric Feeding Disorders Program. We look forward to meeting you and your child.

Sincerely,

Melissa Nieman
Pediatric Feeding Disorders Program
985450 Nebraska Medical Center
Omaha, NE 68198-5450
Telephone: **402.559.7039**
Email: **mnieman@unmc.edu**

Pediatric Feeding Disorders Screening Form

Child's Information		☐ Male ☐ Female
Child's Last Name	Child's First Name	Child's Middle Name
Child's Date of Birth	Child's Medicaid Number	Child's Primary Language

Please complete a section for each caregiver who feeds the child or with whom the child lives.

Primary Caregiver		
Who has legal custody of the child?		
Caregiver's Last Name	Caregiver's First Name	
Relation to Child	Does the child live with this caregiver? Yes or No	
Home Address		
Home Address		
City	State	Zip Code
Cell Telephone Number	Work Telephone Number	Home Telephone Number
Email address	Preferred method of communication	
Other individuals living in the home		

Other Caregiver		
Caregiver 2's Last Name	Caregiver 2's First Name	
Relation to Child	Does the child live with this caregiver? Yes or No	
Home Address		
Home Address		
City	State	Zip Code
Cell Telephone Number	Work Telephone Number	Home Telephone Number
Email address	Preferred method of communication	
Other individuals living in the home		

Other Caregiver		
Caregiver 3's Last Name	Caregiver 3's First Name	
Relation to Child	Does the child live with this caregiver? Yes or No	
Home Address		
Home Address		
City	State	Zip Code
Cell Telephone Number	Work Telephone Number	Home Telephone Number
Email address	Preferred method of communication	
Other individuals living in the home		

Referral Information	
Referral Source Name	Referral Source Name
Affiliation	Affiliation
Address	Address
City, State, Zip code	City, State, Zip Code
Telephone number	Telephone Number

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Child's Physicians	
Pediatrician or Primary Care Physician	
Affiliation	
Address	
City, State, Zip code	
Telephone number	

Gastroenterologist	
Affiliation	
Address	
City, State, Zip code	
Telephone number	

Other Specialists	
Physician Name and Specialty Area	Physician Name and Specialty Area
Telephone Number	Telephone Number
Physician Name and Specialty Area	Physician Name and Specialty Area
Telephone Number	Telephone Number

School or Day Care	
Teacher or Day Care Provider	
Address	
City, State, Zip code	
Telephone number	
Performance in School	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Number of days missed due to illness	Number of days missed in current calendar year
Would they do your child's feeding treatment if we trained them?	☐ Yes ☐ No

Primary Insurance		
Insured's Last Name		Insured's First Name
Relation to Child	Insured's Date of Birth	Insured's Social Security Number
	Insured's Employer	
Insurance Company	Group Number	Policy Number
	Case Manager's Name, if applicable	
	Case Manager's Contact Information	

Secondary Insurance		
Insured's Last Name		Insured's First Name
Relation to Child	Insured's Date of Birth	Insured's Social Security Number
	Employer	
Insurance Company	Group Number	Policy Number
	Case Manager's Name, if applicable	
	Case Manager's contact information	

	Check the statements that describe your child's feeding behavior.		
☐	Dependent on Select Feed Type		
☐	Does not eat enough healthy foods	☐	Eats mostly junk foods
☐	Does not eat any food	☐	Does not drink any liquids
☐	Has inappropriate behavior at meals	☐	Cries and tantrums at meals
☐	Does not swallow food	☐	Does not swallow liquids
☐	Is not growing properly	☐	Vomits during or between meals
☐	Coughs at meals	☐	Gags at meals
☐	Cannot or does not chew	☐	Spits out food or liquids
☐	Eats too much	☐	Other, please describe

	Check your goals for treatment of your child's feeding behavior.		
☐	Decrease my child's dependence on Select Feed Type		
☐	Increase the number of different foods my child eats		
☐	Increase my child's acceptance of foods	☐	Increase my child's acceptance of liquids
☐	Increase swallowing of foods	☐	Increase swallowing of liquids
☐	Decrease inappropriate behavior at meals	☐	Decrease crying and tantrums at meals
☐	Promote weight gain and growth	☐	Decrease vomiting during or between meals
☐	Decrease coughing at meals	☐	Decrease gagging at meals
☐	Teach my child to chew	☐	Decrease spitting food or liquid
☐	Decrease overeating	☐	Other, please describe
☐	Other, please describe	☐	Other, please describe

Write down the time of each meal and what and how much your child eats.		
Here's an example		
Breakfast	7:00 am	1 cup cheerios with 4 oz milk
Breakfast		
Lunch		
Dinner		
Snack		
Other		

Write down the time, type, rate, volume, and method (e.g., gravity) of each nonoral feed.				
Here's an example				
7:00 am	G tube	120 ml/hr	60 ml	pump
Time	Type	Rate	Volume	Method

Formula	**Here's an example**			
Nutrin	Jr	Vanilla	Fiber	2 scoops + 8 oz water
Formula Name	Formula Version	Formula Flavor	Formula Extras	Formula Recipe
Who prescribes or manages your child's formula?				

Please give a copy of Pages 3, 4, and 5 to every caregiver who feeds your child and ask that caregiver to complete the relevant sections.

Tell us what percentage of your child's calories come from (or tell us the total amount your child eats, drinks, or receives if you don't know the percentages)				
Example	10%	10%	80%	0%
	Food	Liquids	Tube Feeds	TPN
Percentage				
Amount				

Meal	**Does your child eat with the family?**		**Where does your child**		**Special things you do before the meal (e.g., turn on tv, give child Ipad, use special utensils)**
	Yes	No	eat	sit	
Breakfast	☐	☐	Select Room	Select Seating	
Lunch	☐	☐	Select Room	Select Seating	
Dinner	☐	☐	Select Room	Select Seating	
Snack	☐	☐	Select Room	Select Seating	
Other	☐	☐	Select Room	Select Seating	

Check the boxes that describe what foods you serve your child at each meal.

I only serve foods I know my child will eat at

☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks ☐ Other

I serve some foods my child usually does not eat and some foods I know my child will eat at

☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks ☐ Other

I serve my child whatever the family is eating whether my child usually eats it or not at

☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks ☐ Other

I do not serve foods to my child at

☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks ☐ Other

How do you let your child know it is time to eat?

Check the boxes that show about how long it takes your child to eat each meal.

	Minutes					
	0-10	11-20	21-30	31-40	41-50	51+
Breakfast	☐	☐	☐	☐	☐	☐
Lunch	☐	☐	☐	☐	☐	☐
Dinner	☐	☐	☐	☐	☐	☐
Snack	☐	☐	☐	☐	☐	☐

My child's appetite is

☐ poor ☐ fair ☐ good ☐ excellent ☐ eats too much

How does your child tell you he or she is hungry?

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Check the boxes that describe your child's current feeding skills.				
My child eats with				
☐ his or her fingers	☐ a fork	☐ a spoon		
My child drinks from				
☐ a bottle	☐ a sippy cup	☐ an open cup	☐ a straw	
What percentage of meals does your child feed him or herself?				
☐ 100%	☐ 75%	☐ 50%	☐ 25%	☐ 0%

Check the boxes on the left that describe what you do when your child refuses to eat or drink. Check the boxes on the right if what you do improves your child's feeding.		**Does feeding improve?**	
		Yes	**No**
☐	I encourage or coax my child to eat or drink (e.g., "you like peas")	☐	☐
☐	I reprimand my child (e.g., "we do not throw food!")	☐	☐
☐	I offer rewards (e.g., "if you eat a pea, I will give you an M&M")	☐	☐
☐	I give my child something I know he or she will eat or drink after refusal behavior	☐	☐
☐	I take away the food or drink my child is refusing	☐	☐
☐	I turn on the television or music or give my child something he or she likes	☐	☐
☐	I end the meal	☐	☐
☐	I send my child to time out	☐	☐
☐	I remove privileges (e.g., no Ipad tonight)	☐	☐
☐	I make my child sit at the table until he or she eats or drinks a certain amount	☐	☐
☐	I let my child leave the table	☐	☐
☐	I let my child eat whenever he or she wants after refusal behavior	☐	☐
☐	I let my child eat wherever he or she wants after refusal behavior	☐	☐
☐	I eat or drink something and tell my child to watch me	☐	☐
☐		☐	☐
☐		☐	☐

List the foods and liquids your child consistently eats and drinks.	
Fruits	
Grains	
Proteins	
Vegetables	
Junk foods	
Liquids	

Feeding History			
Was there a time your child could not eat or drink by mouth?			Yes or No
If yes, how old was your child?	Age of child when oral feeds stopped	to	Age of child when oral feeds started
Why?			

When did your child first begin having feeding problems?

How did you feed your child as an infant?			
☐ breastfed	☐ bottle fed	☐ both	☐ neither

Oral-Motor Skills						
Tell us about your child's history with food textures.						
Food Type	**Does**	**Can**	**Never**	**Can't**	**Has Not**	**Age**
Baby food	☐	☐	☐	☐	☐	
Creamy food (e.g., yogurt)	☐	☐	☐	☐	☐	
Pureed table food	☐	☐	☐	☐	☐	
Mashed table food	☐	☐	☐	☐	☐	
Chopped table food	☐	☐	☐	☐	☐	
Regular table food (e.g., pizza)	☐	☐	☐	☐	☐	
Crispy food (e.g., crackers)	☐	☐	☐	☐	☐	
Crunchy food (e.g., carrot)	☐	☐	☐	☐	☐	
Chewy food (e.g., chicken nugget)	☐	☐	☐	☐	☐	

"**DOES**" means that your child will eat the food most of the time when you serve it.
"**CAN**" means that your child has the skill or ability to eat the food even if he or she does not eat it.
"**NEVER**" means that your child never or rarely will eat the food when you serve it.
"**CAN'T**" means that your child does not have the skill or ability to eat the food even if he or she is willing to eat it.
"**HAS NOT**" means you have never given this to your child .
"**AGE**" means the age of your child when you first gave this texture to him or her.

Check the boxes that describe your child's behavior in the past (had) and now (has).					
Problem	**Has**	**Had**	**Problem**	**Has**	**Had**
Aspiration	☐	☐	Oversensitivity to food temperature	☐	☐
Clearing throat	☐	☐	Oversensitivity to food texture	☐	☐
Coughing while drinking	☐	☐	Penetration	☐	☐
Coughing while eating	☐	☐	Poor lip control	☐	☐
Difficulty swallowing	☐	☐	Poor suck	☐	☐
Gagging while drinking	☐	☐	Poor tongue control	☐	☐
Gagging while eating	☐	☐	Profuse perspiration (diaphoresis)	☐	☐
Grunting	☐	☐	Tongue thrust	☐	☐
Children older than 12 months			Teeth grinding	☐	☐
Difficulty biting off pieces of food	☐	☐	Other	☐	☐
Difficulty chewing	☐	☐	Other	☐	☐

Medical Status	
Current diagnoses	
Previous illnesses	
Surgeries or hospitalizations	
Current medications and dosages	
Allergies to medications	
Allergies to food	
If your child has food allergies, who diagnosed the food allergies and what test(s) did the doctor do?	
Food intolerances or special diet	
Recent stress or changes	

Home Environment	**Yes**	**No**
Smokers in the home?	☐	☐
Pets in the home?	☐	☐

	Yes	**No**
Environmental Allergies	☐	☐
List Environmental Allergies		

Birth History	Yes	No	
Problems during pregnancy	☐	☐	Describe problems during pregnancy
Vaginal delivery	☐	☐	
Problems during delivery	☐	☐	Describe problems during delivery
Pass stool in first 24 hours?	☐	☐	
Birth weight		Birth length	
Child premature?	☐	☐	Gestational age

Gastrointestinal Symptoms					
Problem	**Yes**	**No**	**Problem**	**Yes**	**No**
Appetite change	☐	☐	Jaundice	☐	☐
Gallbladder disease	☐	☐	Liver disease	☐	☐
Heartburn or reflux	☐	☐	Nausea or vomiting	☐	☐
Inflammatory bowel disease	☐	☐	Vomiting blood or bile	☐	☐
Irritable bowel syndrome	☐	☐	Other	☐	☐
Toileting	**Yes**	**No**		**Yes**	**No**
Does your child			**Does your child have**		
urinate in the toilet?	☐	☐	stool accidents?	☐	☐
wet the bed?	☐	☐	black tarry stools?	☐	☐
withhold stools?	☐	☐	blood in the stools?	☐	☐
take laxatives?	☐	☐			
How often does your child stool?			Do the stools vary in consistency?	☐	☐
Abdominal Pain Symptoms	**Yes**	**No**	**Characteristics of Abdominal Pain**		
Abdominal pain	☐	☐	How long has your child had abdominal pain?		
Abdominal pain while sleeping	☐	☐	How long does the pain last?		
Does pain improve with			What treatments have you used for the pain?		
bowel movement?	☐	☐	How does the child tell you he or she has abdominal pain?		
food?	☐	☐	Foods that improve the pain		
Other comments			Foods that worsen the pain		
Review of Systems					
General	**Yes**	**No**			
Unexplained fevers	☐	☐	Bedtime	Enter time	
Unusual fatigue	☐	☐	Wake time	Enter time	
Sleep problems	☐	☐	Nap time	Enter time	
Weight loss	☐	☐	Weight loss over what time period?	Enter dates	
Weight gain	☐	☐	Weight gain over what time period?	Enter dates	

Cardiovascular	Yes	No	Genitourinary	Yes	No
Heart disease	☐	☐	Blood in urine	☐	☐
Heart murmur	☐	☐	Pain with urination	☐	☐
Ear, Nose, Throat	**Yes**	**No**	**Hematology, Lymphatic**	**Yes**	**No**
Frequent ear infections	☐	☐	Bleeding gums	☐	☐
Mouth sores	☐	☐	Enlarged lymph nodes	☐	☐
Sinus problems	☐	☐	Excessive bruising	☐	☐
Endocrine	**Yes**	**No**	History of anemia	☐	☐
Diabetes	☐	☐	Nose bleeds	☐	☐
Growth problems	☐	☐			
Thyroid problems	☐	☐			

Muscular and Skeletal	Yes	No	Respiratory	Yes	No
Back pain	☐	☐	Asthma, wheezing	☐	☐
Joint pain, stiffness	☐	☐	Chronic cough	☐	☐
Neurologic	**Yes**	**No**	Pneumonia	☐	☐
Excessive fussiness or irritability	☐	☐	**Skin**	**Yes**	**No**
Frequent headaches	☐	☐	Eczema	☐	☐
Migraine headaches	☐	☐	Rashes	☐	☐
Seizures	☐	☐	**Immunizations up to date**	☐	☐

Medical Tests	Yes	No	Date	Findings
Colonoscopy	☐	☐		
Endoscopy	☐	☐		
Food allergies	☐	☐		
Gastric emptying	☐	☐		
Modified barium swallow study	☐	☐		
pH probe	☐	☐		
Other	☐	☐		

Procedures	Has	Had	Dates	Comments
G tube	☐	☐		
G-J tube	☐	☐		
J tube	☐	☐		
Nasal cannula	☐	☐		
OG tube	☐	☐		
Tracheostomy	☐	☐		
Other	☐	☐		
Other	☐	☐		

Family History					
Problem	**Yes**	**No**	**Problem**	**Yes**	**No**
Asthma	☐	☐	Environmental allergies	☐	☐
Celiac	☐	☐	Food allergies	☐	☐
Chron's disease	☐	☐	Inflammatory bowel disease	☐	☐
Colitis	☐	☐	Irritable bowel syndrome	☐	☐
Colon cancer	☐	☐	Liver disease	☐	☐
Colon polyps	☐	☐	Mental health disorder	☐	☐
Diabetes	☐	☐	Thyroid disease	☐	☐
Eczema	☐	☐	Ulcerative colitis	☐	☐
Other	☐	☐	Other	☐	☐

Child's Development					
Cognitive	☐ no delays	☐ mild delays	☐ moderate delays	☐ severe delays	☐ profound delays
Communication	☐ vocal	☐ device	☐ gestures	☐ noises	☐ none
	☐ manual signs	☐ picture cards		☐ other	
Ambulation	☐ independent	☐ needs support		☐ uses wheelchair	

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Other Behavior (check if a problem, select severity, and describe when it happens)			
		Select severity:	During what situations does this behavior occur?
☐	anxiety	Select one...	
☐	argues	Select one...	
☐	bangs head	Select one...	
☐	bites self	Select one...	
☐	body rocking	Select one...	
☐	bothers others	Select one...	
☐	breaks things	Select one...	
☐	complains of body pains	Select one...	
☐	communication issues	Select one...	
☐	depression	Select one...	
☐	hand flapping	Select one...	
☐	hits head	Select one...	
☐	hurts other people	Select one...	
☐	insistence on sameness	Select one...	
☐	lacks social skills	Select one...	
☐	lies	Select one...	
☐	phobias	Select one...	
☐	pica	Select one...	
☐	pokes eyes	Select one...	
☐	pulls own hair	Select one...	
☐	runs away	Select one...	
☐	separation anxiety	Select one...	
☐	skips school	Select one...	
☐	social withdrawal	Select one...	
☐	steals	Select one...	
☐	temper tantrums	Select one...	
☐	throws things	Select one...	
☐	thumb sucking	Select one...	
☐	tics	Select one...	
☐	verbally abusive	Select one...	
☐	Other	Select one...	
☐	Other	Select one...	

	Previous Therapy	Dates of Therapy	Times per Month	Length Minutes	Therapy focused on feeding?		Did feeding improve?	
					Yes	No	Yes	No
☐	Early Intervention				☐	☐	☐	☐
☐	Nutrition				☐	☐	☐	☐
☐	Occupational Therapy				☐	☐	☐	☐
☐	Physical Therapy				☐	☐	☐	☐
☐	Speech Therapy				☐	☐	☐	☐
☐					☐	☐	☐	☐

Three-Day Food Record

Pick 3 days to write down what you make your child to eat and drink and what your child ate and drank. Write the dates in the column labeled "date." Write down what you made your child in the column labeled "Food Items." The "Yield" is the amount of food that resulted if you pureed or ground the food. In the example below, four chicken nuggets pureed with ½ cup of milk resulted in 1 cup of the chicken nugget-milk mixture. Disregard this column if you do not blend or grind your child's food. Write down how much your child ate or drank in the column labeled "Amount Consumed." Be as specific as possible. Write down the amount your child eats and drinks in volume (e.g., tablespoons, cups) or weight (e.g., grams, ounces). Include brand names and recipes.

Here's an example.			
Date	**Food Item**	**Yield**	**Amount Consumed**
1/14/17	4 Tyson chicken nuggets, ½ cup whole milk	1 cup	1/3 cup
	Red grapes		3 grapes
	Pediasure		2 cups
	Pringles plain potato chips		25 chips
1/15/17	Eggo waffle, ½ cup whole milk	1.5 cups	2 tbsp.
	Pringles plain potato chips		40 chips
	Pediasure		4 cups
1/16/17	Kraft cheese stick		¼ stick
	Pediasure		2.5 cups
	Skittles		30 Skittles
	Green grapes		2

Three-Day Food Record			
Date	**Food Item**	**Yield**	**Amount Consumed**

Three-Day Food Record (continued)			
Date	**Food Item**	**Yield**	**Amount Consumed**

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