
Intake Questionnaire

Child's Name _____ Child's Date of Birth _____

Child's MR Number _____ Insurance Provider _____

Parent's Name _____ Primary Phone Number _____

Address _____

1. Who referred your child to the Feeding Program?

2. Has your child been seen by the Feeding Team at CHOP in the past? If yes, how long ago?

3. What is your child's feeding problem?

4. What do you hope to get from the evaluation or learn from the team?

5. How much does the child weigh now?

6. Are you concerned about your child's weight and/or growth? ____ Yes ____ No

7. Is your Pediatrician concerned about your child's weight? ____ Yes ____ No

8. Was your child premature? ____ Yes ____ No

If yes, what was the gestational age? (How many weeks early was your child?) _____

9. Is your child receiving tube feeds? ____ Yes ____ No

If yes, please select type: ____ NG tube

____ G tube

____ GJ tube

10. Is your child permitted to drink or eat by mouth?

If yes, what is he/she drinking or eating? ____ Liquids

____ Puree

____ Baby Food

____ Table Food

Intake Questionnaire (continued)

Child's Name _____

11. Does your child see another doctor besides a pediatrician? ____ Yes ____ No
If yes, please provide the physician's name and phone number.

12. Has your child been treated for any of the following medical, developmental and/or mental health diagnoses?

- | | | |
|--|---|---|
| <input type="checkbox"/> GE Reflux | <input type="checkbox"/> Esophagitis | <input type="checkbox"/> Autism/PDD |
| <input type="checkbox"/> Neurologic (brain) issues | <input type="checkbox"/> Pulmonary (lung) issues | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Slow stomach emptying | <input type="checkbox"/> Eosinophilic esophagitis | <input type="checkbox"/> Mental health |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Cardiac issues | <input type="checkbox"/> Failure to thrive/slow growth |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Genetic/chromosome abnormality |

13. Does the child live with his/her biological/adoptive parent(s)? ____ Yes ____ No
If no, who does this child live with (example: foster parent, grandparent, etc)?

14. Who will bring the child to the appointment?

15. Do you need an interpreter? What is your language?

16. What is the name, address and phone number of your child's pediatrician?

17. Are there any other concerns or information about your child that you think would be helpful to share with the Feeding Team?

Please fax to the Access Center for processing. The fax number is 267-426-5934.