Rehabilitation Services/ Pediatric Outpatient Needs Assessment

WHAT ARE YOUR CURRENT CONCERNS REGARDING YOUR CHILD? WHEN DID YOU START NOTICING THESE CONCERNS?
WHAT OTHER THERAPY (I.E. EARLY INTERVENTION, PT, OT, ST) AND/OR SPECIAL EDUCATION PROGRAMS HAS YOUR CHILD HAD? NOW RECEIVING?
IS YOUR CHILD CURRENTLY IN SCHOOL/DAYCARE? IF SO, WHERE AND HOW OFTEN?
WHAT IS YOUR GOAL FOR YOUR VISIT TODAY?

PAST MEDICAL HISTORY: (Please check all that apply)

θ Allergies
θ Asthma
θ Blood Disorders
θ Broken Bones/ Fractures
θ Cancer
θ Depression/Anxiety
θ Diabetes
θ Ear Infections
θ Feeding/Swallowing Problems
θ GERD
θ Head Injury
θ Heart Problems
θ Hearing Loss
θ Infectious Diseases
θ Motor Vehicle Accident
θ Muscular Dystrophy
θ Pre-maturity
θ Seizures
θ Vision Problems
θ Other: _____
_____
_____
_____

Please list and describe any important injuries / surgeries/diagnostic tests and/or illness including ear and chest infections. At what age did these occur?

_____

(to be completed for patients under the age of 8)

DEVELOPMENTAL HISTORY:

Birth: Weight _____ Height _____ Duration of Pregnancy _____

Type of Delivery: _____

Complications at birth: _____

Treatment received by baby or mother: _____

Was your child bottle-fed? θ Yes θ No

Would you describe your child as a baby as easy, fussy, or difficult? (Please describe):

_____

In terms of milestones (i.e. sitting up, crawling, walking and talking): Were they met on time? Yes No

If no, please explain:

_____

_____

_____

FOR FEEDING EVALUATIONS

(if you have been to the multidisciplinary feeding clinic within the last 6 months, you do not need to complete)

What issues are you trying to resolve? Check all that apply.

	Increase the volume of food my child eats		Increase the texture of food my child eats
	Increase the variety of food my child eats		Improve cup drinking
	Improve my child's oral motor skills		Improve mealtime behaviors
	Decrease gagging during eating		Decrease vomiting related to eating
	Reduce/eliminate diarrhea		Reduce/eliminate constipation
	Increase weight gain		Decrease tube feedings
	Resolve reflux or other GI issues		Improve independent eating
	Improve utensil use		Other

When did you first notice problems with feeding? _____

Did your child have difficulty with any stage of feeding or a hard time transitioning from one phase to the next (e.g. from breast to bottle feeding to sippy cup. Or from baby cereal to stage I, II, or III, to table food)? Please explain:

_____

_____

Current Feeding Skills: Check all that apply.

	Feeds self with fingers		Breastfeeding		Drinks from a sippy cup
	Feeds self with spoon		Drinks from a bottle		Drinks from a straw
	Feeds self with fork		Drinks from an open cup		Other

Do you have concerns with any of the following:

	Drooling		Poor lip control		Swallowing problems
	Poor sucking		Problems with biting		Coughing/gagging
	Poor tongue control		Lack of chewing		Increased sensitivity to foods
	Teeth grinding		Irritability while eating		Ruminating/vomiting

Where does your child usually eat? Check all that apply.

	Caregiver's lap		Infant seat		Wheelchair/ seating device
	High chair		Kitchen table/chair		On the go
	Booster Seat		Kids' table/chair		Other

Please list:

a. Favorite foods: _____
b. Disliked foods: _____
c. Foods once eaten that he/she no longer eats: _____

_____

_____

Does your child currently do any of the following behaviors during meals? (Check all that apply)

	Throws Food		Food gets stuck in mouth		Eats too slowly
	Cries/tantrums		Overstuffs mouth		Messy eater
	Overeats		Smells food		Eats non-food items
	Takes food from others		Spits food		Plays with food
	Gags		Leaves table		Licks food
	Eats too fast		Eats too little		Other
	Fails to chew food		Refuses food		Other
	Refuses to swallow food		Vomits		Other

Do you or your child's doctor have concerns with your child's growth or weight gain? _____

_____

Name **Signature** **Date**