110 Ivy Rock Lane
Havertown PA, 19083
Phone: 515-771-6248
Fax: 484-454-5770
www.heartlandfeeding.com

Heartland Pediatric Feeding Disorders Services

Screening Form

Thank you very much for you interest in the Heartland Pediatric Feeding Disorders Services! To best serve you we will need a little information to ascertain if Heartland's services would be appropriate for your child.

Instructions:

Please provide all information requested on this form and return it as soon as possible. Normally, you will hear from us within 3-5 days after receiving the screening packet. We will call to gather additional information and schedule an evaluation, **once we have reviewed this form**. Please, send the completed form to:

Sean D. Casey, Ph.D., BCBA
Heartland Pediatric Feeding Disorders Services
110 Ivy Rock Lane
Havertown PA, 19083

You may also scan and send the completed forms via email to: **Sean.Casey@Heartlandfeeding.com**
You may also fax the completed forms to: 484-454-5770.

Before we schedule an evaluation, we will need copies of the following items:

Your child's most recent medical evaluation and medical records. We are interested in reviewing results from evaluations related to your concerns with feeding. You may wish to contact your child's pediatrician first to see if that office has copies of evaluation reports. Reports may be mailed or emailed to us.

Your child's typical daily mealtime schedule along with 3 day record of daily food intake (a 3 day Food Intake Record is included at the end of this screening packet).

If you have any questions or need assistance please write or call Dr. Sean D. Casey, Ph.D., 515.771.6248.

BIOGRAPHICAL

Child's Name: _____ Date of Birth: _____

Caregivers' Name: _____ Email: _____

Address: _____

City, State, Zip: _____ Telephone: _____

Child's Legal Guardian: _____

Person(s) who Referred you to our program: _____

Has your child ever been treated for his/her feeding issues: ❑ Yes ❑ No

Please list below name, address, and telephone number of the appropriate contact person if not already listed above.

_____

_____

FEEDING DIFFICULTY

On a scale of 1-10, how difficult is your child's feeding concerns (Please circle your answer)?

1 2 3 4 5 6 7 8 9 10

Not at all Difficult Most Difficult Problem

Primary Presenting Problem: (Circle)

Food Selectivity **Total Food Refusal** **Other (see below)**

Definitions:
Food Selective – child does not eat 1 or more major food groups (i.e., vegetable, fruit, protein, starch)
Total Food Refusal – that the child is eating less than 100% of his caloric needs and requires other means for meeting caloric needs (i.e., bottle, tube).

Food Selectivity: If "Food Selectivity" was selected as a primary presenting issue, list the number of foods that your child has eaten 90% of the time when the items are offered over the last 30 days,

a. Starch: _____

b. Fruit: _____

c. Protein: _____

d. Vegetable: _____

e. Other/Snacks:_____

Total Food Refusal: If "Total Food Refusal" was selected as a primary presenting issue, provide the following information:

a. Last 3 weight checks: _____(weight) _____(weight) _____(weight)
_____(date) _____(date) _____(date)

b. Caloric Needs (if known): _____(calories per day)

c. Approximate Calories per day during meals: _____(calories or percentage)

d. Approximate calories per day during supplemental feedings: _____(calories or percentage)

Other: If "Other" was selected as a primary presenting issue, provide a description of the behavior below.

Description of Behavior

a. _____

b. _____

c. _____

d. _____

For each primary presenting problem identified above, please list the approximate date that presenting problem began to occur and how long the issue has been a problem.

	Date of Onset	Months/Years as a Problem
a. Food Selectivity:	_____	_____
b. Total Food Refusal:	_____	_____
c. Other 1:	_____	_____
d. Other 2:	_____	_____
e. Other 3:	_____	_____
e. Other 4:	_____	_____

Provide any additional information here:

PRIOR PROFESSIONAL CONTACTS

Please list all past and current therapies your child has received which directly addressed their feeding difficulties. Include a brief description of the therapy.

Name:_____ Affiliation:_____ Phone:_____

Dates of Service:_____ Therapy: _____

Was the therapy effective?_____ If yes, how?_____

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Name:_____ Affiliation:_____ Phone:_____

Dates of Service:_____ Therapy: _____

Was the therapy effective?_____ If yes, how?_____

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Name:_____ Affiliation:_____ Phone:_____

Dates of Service:_____ Therapy: _____

Was the therapy effective?_____ If yes, how?_____

SCHOOL/DAY CARE

Name:_____ Teacher:_____

Address:_____ Phone:_____

List any special education services your child receives: _____

Has your child's school/day care addressed your child's feeding difficulties? _____

If yes, how?_____

Was this effective?_____ How?_____

MEDICAL INFORMATION

Was feeding interrupted at any time in your child's history? ❑ Yes ❑ No

For how long? _____ For what reason? _____

Diagnoses: _____

Height: _____Weight: _____

Current medical problems: _____

_____

Name of Primary Care Physician: _____Affiliation: _____

Address: _____

Telephone: _____

Name of Gastroenterologist: _____Affiliation: _____

Address: _____

Telephone: _____

Please list any other physicians who are treating your child:

Name: _____Affiliation: _____

Address: _____

Telephone: _____

Name: _____Affiliation: _____

Address: _____

Telephone: _____

Has your child had any recent procedures/surgeries? ❑ Yes ❑ No

If yes, what?_____ Date:_____

Please check if your child has had the tests below.

- ❑ Swallow study (MBS / OPMS) Date:_____ Result:_____
- ❑ Endoscopy Date:_____ Result:_____
- ❑ Gastric Emptying Date:_____ Result:_____
- ❑ pH probe Date:_____ Result:_____
- ❑ Upper GI Date:_____ Result:_____
- ❑ Allergy Testing
  - Skin Test Date:_____ Result:_____
  - Blood Test Date:_____ Result:_____

Were any of the following used during the neonatal/early infancy period?

	Dates	Amount	Formula	% of daily intake	How? Continuous/ Bolus
tracheostomy					
nasal cannula					
G-tube					
NG-tube					
Other					

Bowel Habits:

Frequency of Bowel Movements: _____ times per (circle one): DAY WEEK

Consistency: **HARD** **SOFT** **LOOSE** **WATERY**

Please list any medications your child is currently taking.

Medication	Dosage	Prescribing Doctor

CURRENT FEEDING PRACTICES

Current Skills (Check all that apply.)

a.	❑	Drinks from bottle	Special adaptation, type _____ Does your child hold the bottle?_____ Type of nipple used: _____	
b.	❑	Fed by parents?	How? _____	
c.	❑	Feeds self with fingers?	❑ Large pieces	❑ Small
d.	❑	Feeds self with spoon?	Special adaptations? Type?_____	
			❑ Independent	❑ Needs help
e.	❑	Feeds self with fork?	❑ Independent	❑ Needs help
f.	❑	Uses knife?	❑ Spreads	❑ Cuts
g.	❑	Drinks from cup/glass?	List special adaptations _____ _____	
h.	❑	Drinks from straw?		
i.	❑	Pours own drink?		
j.	❑	Prepares own snack?		
k.	❑	Has child ever self-fed?		
l.	How is your child positioned for feeding?		❑ Regular chair @ table ❑ Booster seat ❑ High chair ❑ Reclined chair ❑ Adaptive chair, type: _____ ❑ Other:	

Where does your child typically eat? ❑ adult's lap ❑ booster seat ❑ infant seat ❑ table/chair ❑ high chair ❑ other (please specify) _____

My child typically eats: ❑ Alone ❑ With the family

Does your child have behavior problems during meal times? ❑ Yes ❑ No

Check all behaviors, which are **problematic** during mealtimes:

	Only eats certain foods (food selective)		Whines, cries, screams, or tantrums during meals
	Passively refuses food (e.g., will not open mouth)		Aggression
	Actively refuses food (e.g., turns head, bats spoon)		Self-injury
	Spits out food (i.e., expels food)		Leaves the table before finished
	Packs food (chipmunks/will not swallow)		Takes food from others
	Vomits during, or just before, or right after meals		Overeats
	Eats too slow/too fast (circle which one)	Other:	

What do you do when your child has behavior problems during a meal? _____

_____

At what age were solids introduced? _____

Was a nipple/pacifier used during neonatal period? ❑ Yes ❑ No

During infancy, was child fed by: ❑ bottle ❑ breast ❑ combination

Food consistency: please check all that are currently applicable:

	does eat	can eat	never eats	can't eat	has not tried
liquids/soups	_____	_____	_____	_____	_____
strained baby food	_____	_____	_____	_____	_____
junior baby	_____	_____	_____	_____	_____
creamy foods (ice cream, yogurt)	_____	_____	_____	_____	_____
blenderized table food	_____	_____	_____	_____	_____
mashed table food	_____	_____	_____	_____	_____
chopped table food	_____	_____	_____	_____	_____
regular table food	_____	_____	_____	_____	_____
crisp foods (crackers, toast)	_____	_____	_____	_____	_____
chewy foods (meat)	_____	_____	_____	_____	_____
crunchy foods (carrots, celery)	_____	_____	_____	_____	_____

List any additional foods and drinks that your child consistently accepts:

dairy products _____

sweets _____

Why do you think your child refuses foods/liquids? _____

_____

Describe any special diet _____

Meal Pattern

Please indicate your child's typical mealtime schedule and sample meals. Give approximate amounts.

	Sample/Typical Meal	Approximate Mealtime
Morning -	_____	_____
Afternoon -	_____	_____
Evening -	_____	_____
Snacks -	_____	_____

Describe the sequence in which food is offered to your child (i.e., liquids always first, etc.):

_____

Does your child's food habits and preferences match the family's? ❑ Yes ❑ No

Does your child eat little meals and snacks throughout the day? ❑ Yes ❑ No

Your child's appetite is best described as (circle one):

poor fair good excellent eats too much

How long does it take for your child to complete a meal? (circle one)

less than 10 minutes **10-20 minutes** **20-30 minutes** **over 60 minutes**

How does your child indicate hunger? _____

What do you do when your child refuses to eat/drink_____

_____

ORAL MOTOR STATUS

Check all behaviors, which are **problematic** during mealtimes:

	Drooling		Vomiting/Rumination
	Continuous sucking; poor sucking		Teeth Grinding
	Biting (independently biting off pieces of food)		Coughing
	Tongue control (tongue thrust, poor mobility)		Gagging
	Swallowing		Profuse perspiration (diaphoresis)
	Lip control (keeping his/her mouth closed)		Aspiration
	Chewing (for children over 12 months)	Other:	
	Hypersensitivity to food textures, temperature, spoon		

ADAPTIVE BEHAVIOR

Check each of the following that apply to your child:

- ❑ Ambulatory (walking)
- ❑ Uses words or signs to communicate
- ❑ Can imitate a model
- ❑ Follows instruction
- ❑ Visually impaired
- ❑ Hearing impaired
- ❑ Toilet trained

Concerns w/ toileting: _____

Estimated level of functioning (circle the one that best describes your child):

Typically Developing | Mild Intellectual Disability | Moderate Intellectual Disability | Severe Intellectual Disability | Profound Intellectual Disability

OTHER BEHAVIORS

Record any other problem behaviors your child displays and describe it specifically. Include any damage resulting form the problem behavior either to your child or others. Please list in order of concern to yourself of other caretakers, with the behavior of most concern listed first.

	Behavior	Description
a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____

Estimate the severity of the problem behavior above of greatest concern (circle one).

Moderate Severe Life-threatening

Other information pertinent to severity, risk, etc.: _____
_____

Estimate the current frequency of the problem behavior(s) (check one).

- ❑ Less than one episode per week (list frequency): _____
- ❑ 1 to 3 episodes per week
- ❑ Occurs about once daily
- ❑ Occurs several times per day
- ❑ Occurs every hour while awake

How long has your child been engaging in the problem behavior(s) (circle one)?

- ❑ Within past 6 months
- ❑ More than 6 months but less than 1 year
- ❑ More than 1 year but less than 3 years
- ❑ More than 3 years but less than 5 years
- ❑ More than 5 years but less than 10 years

When is(are) the problem behavior(s) likely to occur (circle all that apply)?

- ❑ When the child is left alone or unattended
- ❑ When lots of people are around
- ❑ When demands are placed on the child
- ❑ When preferred items are restricted
- ❑ Mealtimes, dressing, or bathing (circle)
- ❑ Other: _____

Does your child appear to enjoy social interaction? ❑ Yes ❑ No

Does your child require special supervision (for example, to avoid self-injury)? ❑ Yes ❑ No

If yes, explain: _____

Does your child have problems going to sleep at night? ❑ Yes ❑ No

If yes, explain: _____

Is your child toilet trained? ❑ Yes ❑ No

Are there any concerns with toileting? ❑ Yes ❑ No

If yes, explain: _____

EDUCATIONAL INFORMATION

Does your child have an IEP? ❑ Yes ❑ No

If, "Yes", is Feeding listed as a feeding goal? ❑ Yes ❑ No

If, "Yes", please describe the goal as it is written on the IEP (You can also provide a copy of the goal and ask the school/early intervention therapist for any data related to the goal indicating progress. (i.e., graphs):

Goal: _____

FINANCIAL INFORMATION *(Please include a photocopy of the card(s) – both front and back*

Does your child have medical insurance? ❑ Yes ❑ No

If yes, what company? _____

Policy # and holder: _____

Group #: _____ Type: _____

If no, how would hospitalization be covered?: _____

_____

Does your child have secondary medical insurance? ❑ Yes ❑ No

If yes, what company? _____

Policy # and holder: _____

Group #: _____ Type: _____

If no, how would hospitalization be covered?: _____

_____

If the feeding program developed through our service is effective in improving your child's mealtime behaviors, describe the resources you have available to maintain this program (e.g., family member support, home health nurses, school personnel).

_____

_____

If there anything else would you like for us to know please indicate on separate pages as necessary?
Thank you for taking the time to fill out this information!

THREE DAY FOOD RECORD

Instructions: Record all food/fluid consumed during the next three days. Please be as specific as possible to ensure accuracy of the analysis. Record the amount eaten in either volume (tbsp, cup) or weight (g, oz) measurements. Include brand names and methods of preparation when appropriate

Note: If an altered texture is being consumed i.e., pureed table food or wet ground, the yield of the "mixture" should be recorded as well as the amount consumed.

For example:

Date:	**Food Item:**	**Yield:**	**Amount Eaten:**
4/13/12	pureed chicken nuggets (4 nuggets, 1/2 c whole milk)	1 cup	1/3 of the cup
	carrots, canned		3 tbs.
	red grapes		35 grapes
	Kraft shells and cheese		Approximately 1/2 cup
	Homemade Mango Shake (1 c mango, 1 1/2 c Wh. Milk)	2 cup	3/4 of the 2 cups
	Tubefeeding: pediasure		480 cc/ml

Date:	Food Item:	Yield:	Amount Eaten:

Date:	Food Item:	Yield:	Amount Eaten:

Date:	Food Item:	Yield:	Amount Eaten: