Lowell General Hospital
Complete connected care℠

Pediatric Growth and Nutrition Clinic – Saints Campus

Pre-admission Questionnaire

Please take some time to answer these questions that will help us to understand your child's growth and feeding concerns.

Child's Name: _____ Date of Birth: _____
Address: _____
Phone: (best way to reach you) : _____

Birth History

Birth Weight: _____ Birth Length: _____ Full term or Premature: _____
Labor/Delivery Problems: _____
_____

Child's Medical History

Has your child been hospitalized since birth ? _____ If yes, please explain: _____
_____

Current Medications: _____
Allergies: _____
Ear infections? _____ If yes, approximately how many? _____
Are immunizations up to date? _____ Developmental Milestones: Normal or Delayed

Feeding History

Breast or bottle: _____ How long: _____ If formula, what type ? _____
Tube Feeding:_____ Formula:_____
Did your child transition to table food well?_____
Feeding problems: _____

Family History (please circle all that apply)

Seizures	Diabetes	Thyroid	Heart disease	Cancer
Stroke	Asthma	Arthritis	Hepatitis	Anemia
Mental illness	Depression	Eating disorders		

Other: _____
Allergies (please describe): _____
Stomach problems (please describe): _____

Child's Current Symptoms (please circle all that apply)

Poor weight gain / Wt loss	Vomiting	Gagging	Long meal times
Diarrhea	Constipation	Stomach distress/pain	Hard to feed
Poor appetite	Trouble sleeping	Stomach looks too big	Difficulty chewing
Picky eater	Snoring/loud breathing	Cannot breathe through nose	Difficulty swallowing

_____

Rate your stress or frustration level: (on scale of a low of 1-10 high) _____

Feeding Routines

Who feeds your child most of his/her meals? _____
Who else feeds your child? _____
When does your child eat: __ Whenever he/she is hungry __ Same times each day __ Snacks or has little meals throughout the day

Your child's appetite is best described as (circle one): Poor Fair Good Excellent Eats too much Varies every day

Do you and your child enjoy mealtimes? Y N _____
How long does it take your child to eat (circle one): Less than 10 minutes 10-20 minutes 20-30 minutes over 60 minutes
How do you know your child is hungry ? _____
What do you do when your child refuses to eat or drink ? _____
_____

Chewing and Swallowing

Does your child gag or cough or choke on foods or liquids ? Explain _____
Does your child prefer liquids or solids ? _____
Does your child have trouble chewing or swallowing? _____
Does your child cry or seem uncomfortable during or after eating ? _____
_____

Drinking Preference Inventory (Please fill in the blanks with how much: 1 cup = 8 oz, 1 can etc., include Brand names)

Does your child drink a supplement: Boost_____ Pediasure _____Other (specify) _____
What kind of milk does your child drink? Whole ____ 2% _____ 1% ____ Skim ____ Soy _____ Rice _____ Flavor_____
Does your child drink: Hot chocolate___ Milk shakes____ Drinkable yogurt_____ Juice_____ Water_____
Favorite foods _____

How can we help you? Why were you referred to the Growth and Nutrition Clinic ? _____
_____
_____

What issues are you trying to resolve? (Check as many as apply)

	Increase the volume of food my child eats		Increase the texture of food my child eats		Stop short order cooking
	Increase the variety of food my child eats		Improve cup drinking		Decrease tube feeding
	Improve motor skills		Improve mealtime behaviors		Other:
	Decrease gagging during eating		Decrease vomiting related to eating		
	Reduce/eliminate diarrhea		Reduce/eliminate constipation		
	Increase weight gain		Resolve reflux or other GI issues		

_____

Was feeding interrupted at any time in the child's history? __Yes ___No

a. For how long?_____
b. For what reason?_____

Where your the child eat? (Check all that apply)

	Caregiver's lap		Booster seat		In front of TV
	Infant seat		High chair		With family
	Chair at the table		Day Care		Other:

Does your child have any of these issues at mealtime? (Check all that apply)

	Throws food during meals		Messy eater		Overeats
	Spits out food		Takes food from others		Leaves the table before finished
	Cries or screams at meal time		Refuses to self-feed		

Current food skills (check all that apply)

___Drinks from bottle ___held by caregiver __child holds bottle ___Feeds self with fingers

___Drinks from open cup/glass __With help __Without help ___Feeds self with spoon __With help __Without help

___Drinks from sippy/tippy cup __With help __Without help ___Feeds self with fork __With help __Without help

Thank you for taking the time to fill out this questionnaire. We look forward to working with you and your child.