Inova Loudoun Pediatric & Adult Rehabilitation Center

44035 Riverside Parkway
Suite 500A
Leesburg, VA 20176
Phone: (703) 858-6667
Fax: (703) 858-6665

Welcome to Our Program

Hello and welcome to ***Inova Loudoun Rehabilitation Center's*** Feeding and Swallowing Center at Lansdowne. We are happy that you have chosen our program to address your child's feeding and/or swallowing needs. Our mission is to evaluate and treat a spectrum of feeding aversions, disorders, and swallowing problems experienced by infants and children on an outpatient basis.

We are very fortunate to have a number of professionals from a variety of backgrounds that are either on staff here at our facility or whom we work very closely with from other offices. The main goal of our program is to evaluate and treat your child as an individual, rather than only looking at the feeding and/or swallowing problem as a separate issue. Often a feeding or swallowing problem is the result of one or more factors and is not simply a behavioral issue in that your child just does not want to eat. This is why we feel that it is very important to look at the whole child, and to use our skills and knowledge for ongoing evaluation and problem solving throughout the therapy process. We do not use one specific therapy approach. We use the approach that works best for your child and your family. As a result, we are able to achieve success with a wide variety of children who have a wide variety of diagnoses including food refusals, gastroesophageal reflux disease (GERD), oral aversions, poor weight gain, failure to thrive, oral motor problems, sensory integration dysfunction, pharyngeal dysphagia, and children with feeding tubes.

The rehab team at our feeding and swallowing center is comprised of **pediatric therapists** who are used to a variety of personalities, behaviors, nap schedules and daycare or school situations. We realize that being flexible is a must when working with children.

We are very excited about the work that we do and we hope that it shows in our evaluations and therapy sessions. Feeding problems can be very serious and are often times very stressful on the entire family. We realize this and we strive to meet the needs of your child as well as your family's needs throughout the therapy process. Please feel free to voice any concerns to us or our office staff at any time.

We look forward to seeing you in our kitchen!

The Pediatric Rehabilitation staff

Pediatric Feeding & Swallowing Center
Intake Form

Biographical

Child's Name: ________________________ Sex: M/F Date of Birth: ______________

Parents Name- Mother: ______________ Father:__________________________________

Address: ___________________________ City, State, Zip: _______________________________

Home Phone: ______________________ Cell: ____________________________________

Other Caregivers (i.e. nanny, daycare provider, etc): ___________________________________
____

Siblings (name & age): ____

Feeding Issues

What is your major feeding concern? Please describe feeding problem.
____
____
____
____

What is your feeding goal(s) for your child? ____
____
____

Medical Team

Name of Primary Care Physician/Pediatrician: ____________________________________
Address: ____
Phone: _____________________________ Fax: _____________________________________
Name of Gastroenterologist: ____
Address: ____
Phone: _____________________________ Fax: _____________________________________
Please list any other specialists who are treating your child:
Name: ____
Address: ____
Phone: _____________________________ Fax: _____________________________________
Name: ____
Address: ____
Phone: _____________________________ Fax: _____________________________________

Is your child participating in an Early Intervention Program? Y/N
If yes, please list therapists involved (i.e. SLP, OT, PT, nutritionist, etc):
Name: ______________________________ Title: __________________________________
Name: ______________________________ Title: __________________________________
Name: ______________________________ Title: __________________________________

Medical Information

Medical Diagnoses: ____
____

Pregnancy details: Full term/Premature Vaginal/C-Section

Assisted Birth: N/Y- Forceps/Vacuum Apgar Scores (if known): ________________

Complications during pregnancy or during/following delivery: No/Yes __________________
____

Respiratory/Nutritional support: No/Yes ____

Feeding tube? No/Yes (If yes, please complete additional Tube Feeding Intake Form).

If yes, describe:____

Overall Development: Normal/Delayed. If delayed, what areas? _________________________
____

Hospitalizations (month/year & reason): ____
____

Current Health: Well/Frequent illness (Please circle any that apply):

Ear Infections	Eczema	Irritability	Upper Respiratory Infections
Seizures	Pneumonia	Rotavirus	Aspiration

Other____

Current Weight: _________________ Current Length/Height: ___________

Medications (name, dose): ____
____
____

Vitamin supplement? N/Y Please list kind: ___________________ Frequency: _______________

Please check if your child has had the procedures below:

Procedure	Date	Results
Swallow Study (MBSS/ OPMS)	Date: _________	Results:__________________
Endoscopy	Date: _________	Results: _________________
Gastric Emptying	Date: _________	Results: _________________
pH probe	Date: _________	Results: _________________
Upper GI	Date: _________	Results: _________________
Allergy Testing		
Skin Test	Date: _________	Results: _________________
Blood Test	Date: _________	Results: _________________

Describe any special diet or food intolerance: ____
____

Bowel Habits:

Frequency of Bowel Movements ______ times per day/week (circle one).

Consistency: ____________________ Mucous/ Blood

Feeding History

Breast? N/Y If yes, at what age was your child weaned? NA/Age ________________________

If currently breastfeeding, please describe schedule _____________________________________

Bottle fed : N/Y Breast milk/Formula? Current formula: ___________________________

Formula type: Powder/Concentrate/Ready-to-feed Please describe how you prepare (i.e. 4

oz water, 2 scoops powder): ____

List any previous formulas & describe tolerance: ______________________________
____
____
Other fluids presented in bottle: ______________________________________

Solids: at what age where cereals/ baby foods introduced? __________ Any problems?
____

Please circle the Stages of baby food that your child ate/eats: 1st/2nd/3rd/Toddler/DICES
Any problems? ____

When were table foods introduced? _________________ Any problems? ____________
____

Does your child have any of the following? Please indicate when problem started.

Food Refusal (refusing all or most foods). Age started: ________

Food Selectivity by texture (eating only textures that are NOT age appropriate
Age started: _______

Food Selectivity by Type (eating a limited variety of foods. Age started: ______

Oral motor delays (problems with chewing, etc). Age started: ________

Dysphagia (problems with swallowing). Age started: __________

Abnormal preferences (temperature sensitive, color specific, particular brands).
Please describe: ____

Other feeding problems: ____

Current Meal Pattern
Which meal is your child's best? _______________ Worst? ____________________

How long does a 'typical' meal take? ____

Please List preferred foods: ____
____
____
____
____
Please list non-preferred foods: ____
____
____
____
Please indicate your child's typical meal schedule. Number of meals/snacks:
____
Timing of meals/snacks: ____
Describe sequence in which food/liquids are offered (i.e. liquids first): _______________
____

Feeding Behavior

Does your child experience any of the following with feeding? N/Y

Choking	Yes/No	Difficulty Chewing	Yes/No
Gagging	Yes/No	Coughing	Yes/No
Vomiting	Yes/No	Overstuffs mouth	Yes/No
Drooling	Yes/No	Teeth Grinding	Yes/No
Hypersensitive	Yes/No	Penetration/Aspiration	Yes/No
Sweating	Yes/No	Problem with biting	Yes/No

Other____

Feeding Behavior

Does your child exhibit any of these behaviors at mealtimes? N/Y Circle all that apply.

Cries or screams	Messy	Refuses to Self-feed
Spits food out	Throws food	Eats to fast/slow
Plays with food	Picky Eater	Pushes food away
Does not suck	Refuses to swallow	Induces Vomiting
Leaves table	Wants 'down'	Refuses to open mouth
Eats non-food items	Clenches lips shut	Turns away from spoon

Other: ____

Do you think your child feels hunger? Yes/No

How does your child indicate hunger? ______________________________

What do you do if your child refuses to eat/drink? ______________________________

____

____

Feeding Practices

Who feeds your child? ______________________________

Does your child eat better for a particular feeder? N/Y Who? ____________________

Where does your child currently eat (circle all that apply):

Adult's Lap	Infant seat	High chair	Booster
Table/Chair	Sofa	Crib/Bed	Car seat
Modified Chair	Wheel chair	Tumble form	

Roaming- Kitchen/other rooms in the house Other :____________________

What feeding techniques do you use with your child to get him/her to eat? Please circle.

Coax	Distract with TV/toys	Provide 'favorite' foods'
Threaten	Change meal schedule	Send to room/time out
Ignore	Offer reward	Force feed
Punish	Praise	Provide 'mini-meals'
Change foods	Allow grazing/roaming	Chase around house with food

Other: ____

What does your child drink from (circle please):

Bottle   Sippy Cup   Open Cup   Straw

Is your child able to self-feed? Yes/No   spoon   fork

Day Care/School

Name of daycare/school: ___________________________ Director: _________________________

Address: ____________________________________ Phone: ___________________________

What meals are provided? Please circle.

Breakfast   Snack   Lunch   Dinner

Do you provide food/beverages? Yes/No

If so, please describe:____

____

____

Is there something we did not ask, that you think would be helpful for us to know:

____

____

____

____

____

____

______________________________ ____________________ __________________

Signature   Relationship to child   Date

We look forward to meeting you and your child !

Food Intake Records

Instructions:
Please record all food/fluid consumed by your child for 2-3 days. The days chosen should represent your child's 'usual' intake. Do not record if your child is sick. The food intake records **must** be received 48 hours **BEFORE** your child's scheduled evaluation. Please return completed forms by:

Faxing to: Inova Loudoun Rehabilitation Center: 703-858-6665
Attention: Debbie Teune for feeding evaluations
or Sheree Hughes for pediatric dietician evaluations

Emailing to: debra.teune@inova.org Subject: feeding/nutrition

Mail to: Inova Loudoun Rehabilitation Center
Attn: Feeding/Nutrition
44035 Riverside Pkwy., Suite 500A
Leesburg, VA 20176

Name:_______________________________

Meal type – Breakfast (B), Lunch (L), Dinner (D), Snack (S)

Date	Time	Meal Type	Food	Beverage	Amount

Name:______________________________________

Meal type – Breakfast (B), Lunch (L), Dinner (D), Snack (S)

Date	Time	Meal Type	Food	Beverage	Amount

For Your Child’s Feeding Evaluation….

Please bring:

Food & drink items that your child likes, as well as foods the she/he has difficulty with.

Your child’s utensils, such as bottle, cup, spoon &/or fork.

Your insurance card, photo ID and the prescription from your doctor ordering speech therapy for feeding difficulties.

A referral if required by your insurance.

Your child **HUNGRY!!**

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PEDIATRIC CASE HISTORY FORM

We ask that you please fill out this form as completely as possible. This information will assist us in understanding your child's present developmental issue(s) and will aid us in planning appropriate testing and/or treatment procedures. ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE INFORM US IF AT ANY TIME THIS INFORMATION CHANGES.

***PLEASE NOTE: AFTER COMPLETION, PLEASE RETURN THIS FORM, ALONG WITH ANY OTHER PERTINENT ACADEMIC and/or MEDICAL REPORTS (e.g. IEP's, previous therapy evaluations, Hospital discharge summaries, etc.) TO THE CENTER. AS SOON AS WE RECEIVE THIS INFORMATION WE WILL CONTACT YOU TO SCHEDULE AN APPOINTMENT. You can fax this completed form to 703-858-6665 or mail/drop off to the address above.*

We thank you in advance for your time and effort in completing this form.

Form Completed by: ________________________ **Relationship to child:** ________________ **Today's Date** _________________

I. FAMILY INFORMATION

Child's Name____ Nickname______________________

Date of Birth______________ Age______ Sex_____ Blog/Website____________________________

Address____

City___________________________________State_________________ Zip Code______________

Reason for referral____

____

Parent's Marital Status: *(circle one)* never married / married / separated / divorced / widowed

Father	Mother
Father's Name______________________________	Mother's Name______________________________
Date of Birth______________________________	Date of Birth______________________________
Address (if different)______________________	Address (if different)______________________
____	____
Telephone:	Telephone:
Home______________________________________	Home______________________________________
Work______________________________________	Work______________________________________
Cell_______________________________________	Cell_______________________________________
Email______________________________________	Email______________________________________
Employer___________________________________	Employer___________________________________
Position___________________________________	Position___________________________________
Primary Language___________________________	Primary Language___________________________
Birth / Adoptive / Foster or Step Parent	Birth / Adoptive / Foster or Step Parent

Please List names and ages of all other people living in the home:

Name	Age	Relationship	Primary Language	Secondary
____________________	_____	______________	___________________________	__________________
____________________	_____	______________	___________________________	__________________
____________________	_____	______________	___________________________	__________________
____________________	_____	______________	___________________________	__________________

II. BIRTH HISTORY

Pregnancy: ____normal or ____complicated by______________________________________

Labor: _____spontaneous____induced ____premature ____complicated by____________________

____

Delivery: ____Cesarean ____Vaginal ____Breech ____VBAC ____Forceps ____ Vacuum

Apgar Score: (if known) __________

Single Birth: _______ **Multiple Births:** ____twins ____triplets ____other________________

Gestational Age: ____ weeks **Birth Weight:** _____ lbs. __ Oz. / _________ grams

NICU: ____No ____Yes__________ days ________ weeks ________ months

Other complications: **(e.g. breathing difficulties, tube feeding)** ___________________________

____

III. RELEVANT MEDICAL HISTORY

Illnesses / Injuries / Surgeries / Hospitalization since birth:

____ High Fevers ____ Head Injury ____ Bone Fracture ____ Frequent ear infections

____ Pneumonia ____ PDA Repair ____ Cleft Palate/Lip ____ NG/G tube insertion

____Encephalitis ____VP Shunt ____Other______________________________

Current Medications: ____

____

Supplements: ____

Allergies: ____

Immunizations: Regular Schedule / Altered Schedule / Other ____________________________

List any medical diagnoses with which your child has been labeled:

____

Pediatrician / Family Physician: ____

Check and list any other healthcare professionals/surgeons involved in your child's care:

____ Neurologist ____ Orthopedist ____ Ophthalmologist/Optometrist

____ Osteopath ____ Chiropractor ____ Developmental Pediatrician

____ Dietician ____ ENT ____ Psychologist/Psychiatrist

____ Feldenkrais ____ Massage ____ Craniosacral Therapist

____ Audiologist: Last hearing screening and results: _____________________________________

____ Other: ____

Previous Therapy Interventions (*early intervention, school-based, etc.*): ________________________

____

Date of most recent psychological / developmental evaluation: ______________________________

Dates of any medical tests such as MRI, CT scan, X-rays: __________________________________

Other diagnostic tests and results: ____

Other relevant FAMILY medical history: (i.e. learning disabilities, autism, genetic disorders, heart or breathing difficulties, allergies): ____

____

IV. DEVELOPMENTAL HISTORY (Please note approximate age in months for each)

Rolled Over: ____________stomach to back ______________back to stomach

Sitting: ____________stayed sitting when placed ______________got self into sitting

Crawling: ______________on belly __________________on hands & knees

Standing: ______________with support ________________pulled self to stand

Walking: ______________with support ______________ cruising around furniture

____________ without support ____________walking independently more than 10 steps

Walking on toes: ____never ____rarely _____occasionally ____frequently

Falls: ____never ____rarely _____occasionally ____frequently

Baby Devices Used: *(age & hours per day)*

__________Sling Swing __________Exersaucer __________ High Chair

__________Jumper __________Pac'n Play __________Bumbo or other sitter

Sensory Tolerance: (Check all that apply)

____ Allows feet to leave ground when swinging ____ Tolerates bare feet on variety of surfaces

____ Tolerates variety of body positions without fear (i.e. on back, off ground, etc.)

____ Tips head back during bathing/diaper changing w/o anxiety

Comments: ____

Toileting: (Check all that apply) ____ urinates/defecates in toilet when placed there

____ Initiating use of toilet ____ Reliably uses toilet ____ Stopped wearing diapers

Communication: (Check all that apply)

____ Looks at caregiver ____ Smiles ____ Coos/babbles

____ Gestures bye-bye ____ Uses 5 words ____ Imitates sounds

____ Responds to name ____ Plays peek-a-boo ____ Puts two words together

____Uses jargon (words that are not understandable but said in "sentences" where child's inflection lets you know he is saying "something") ____ Speaks in sentences

Feeding: (Check all that apply)

____ bottle ____ cup ____ straw ____ NG/G-tube (feeding schedule) ____________________

____ solids ____ pureed ____ chunky/table food _____has been exposed to nuts

Comments ____

Fine Motor Skills: Fill out appropriate age category and check all that apply

- **Babies/Preschoolers:** ____ Holds objects ____ Brings hands to mouth

____ Holds objects in both hands simultaneously ____ Feeds self with fingers

____ Bangs two objects together ____ Feeds self with utensils

____ Manipulating toys like pop beads or shape sorters ____ Scribbling

Comments: ____

- **Preschoolers/Elementary**: Preferred hand: ____ right ____ left

____ Dresses self independently ____ Uses fasteners on clothing

____ Grasps crayon/pencil (thumb and finger) ____ Uses scissors

Comments: ____

- **Elementary/Secondary:**

____ Handwriting issues, explain____

V. SPEECH AND LANGUAGE INFORMATION

How does your child communicate with you? (pointing, grunting, gesturing, words, sentences, sign language, bring parent to item, etc) ____

Has speech development ____stopped? _____ reversed? If so, when, why, explain:

____

Please check any items listed below that are *DIFFICULT* for your child:

___Eating a variety of foods ___Recognizing common words

___Understanding what he/she hears ___Rhyming

___Following directions or routines ___Getting his/her point across

___Answering questions ___Thinking of words for things

___Concepts of time (seasons, day/night, hours) ___Pronouncing words correctly

___Singing sounds/reciting nursery rhymes ___Using a straw

___Stating sounds of letters ___Telling/retelling stories

___Speaking in organizing/grammatically correct sentences ___Blowing bubbles

VI. EDUCATIONAL INFORMATION

Name of school/daycare provider (in/out of home): ___________________________________

List number of hours per week child is around children his/her same age: _____________________

Describe your child's interaction with peers: ____

____

List your school/daycare schedule:

	Mon	Tues	Wed	Thurs	Fri
Hours:	_____	_____	_____	_____	_____

Present classroom teacher / special education teacher / therapist's name: ____________________

Additional Information: ____

Please check any areas of difficulty:

___Speech ___Writing sentences/paragraphs ___Organization ___ Handwriting ___Fine motor

___Reading ___Spelling ___ Math ___Attention ___Study habits ___Mobility ___Gym class

Please list your child's academic strengths: ____

What kinds of grades/reports does your child receive? ____

Describe your child's attitude toward school: ____

Date of most recent educational evaluation, if applicable: ____

VI. BEHAVIORAL HISTORY

Please check all that describe your child:

__Friendly/easy going

__Difficulty sleeping

__Hyperactive

__Attentive

__Sleeps well

__ Shy

__Takes turns/shares objects

__Grinds teeth

__Still uses pacifier/sucks thumb

__ Distractible/short attention span

__Fearful when moved/startles easily

__Impulsive/impatient

__Poor eye contact

__Overly sensitive to sounds

__Has temper tantrums

__Eats well

__Plays make-believe

__Doesn't like to be touched

__Easily frustrated

__Clumsy/falls a lot

__ Will not eat/touch certain textures

__ Cannot easily shift from one activity to another

__Difficulty leaving parent

__Plays well with others

__Cooperative

__Shows affection

__ Daydreams often

__Mouth breather/snores

__Poor memory

__Stubborn

__Cries easily

VII. CHILD'S INTERESTS

Describe your child's play activities / hobbies: ____

Approximate number of hours per week your child watches T.V. _________________________________

Does your child attend community recreation classes, if so, please list: __________________________

____

What incentives / rewards motivate your child? (stickers, food, privileges): _______________________

What method of discipline do you practice at home with your child and is it effective? _______________

____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my child's identifiable health information __/__/__ (current date) to __/__/__ (maximum six months). *I understand that this authorization is voluntary and may be revoked at any time. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.*

Client Name: ____ Date of Birth: ___________________________

Parent/Guardian Signature: ____

<u>Inova Loudoun Pediatric & Adult Rehabilitation Center Service Policies</u>

We would like to take this opportunity to welcome you to Inova Loudoun Pediatric and Adult Rehabilitation. Our Center's mission is to provide excellent care to each patient in a timely manner. Our licensed and certified therapists and our front office staff are committed to providing you the highest quality services. In order for us to deliver care in the most efficient and effective way, we request your assistance in complying with our policies which we have established to guarantee you optimal care and progress.

1) Consistent attendance, crucial to progress during your course of treatment, is required.

2) All appointments are scheduled to allow for direct treatment, consultation and documentation. All appointments need to begin and end on time. Failure to be prompt for an appointment will reduce the amount of time available for treatment and interfere with treatment progress.

3) **Failure to show up for your scheduled appointment and/or a cancellation with less than 24 hours notice will result in an automatic charge of $50.00 *<u>which must be paid prior to resuming services</u>*. Cancellation fees cannot be billed to insurance. Appointments are in HIGH demand and your early cancellation will give another person the opportunity to have access to timely care. <u>Multiple cancellations (more than 1 in a 3 month period) and/or no-shows (more than 1) will result in "Same Day Scheduling" pending extenuating circumstances to be determined by your therapist(s)</u>. "Same Day Scheduling" refers to when an appointment is requested by the client and scheduled on the same day it is to take place. Availability of appointments can not be guaranteed.**

4) We highly encourage any cancelled/missed appointments to be made up. Should you wish to make- up an appointment, please call the office for availability.

5) Front desk staff is responsible for cancellations and rescheduling of all appointments. All questions regarding services, insurance or billing should be directed initially to the front desk staff.

6) When a therapist is unable to keep a scheduled appointment with a client, the service may be provided by another qualified therapist upon the request of the client/responsible party as scheduling permits.

7) Payments are due at the time service is rendered. All clients are ultimately responsible for the cost of appointments scheduled and services received. Our Center will submit charges and accept reimbursement from insurance companies for which we are a provider. Please keep the front office staff informed of any insurance changes. Charges for claims denied will resort to the client for immediate payment. **<u>Please make sure you are aware and keep track of your insurance benefits.</u>**

8) Please give at least (2) weeks notice prior to discontinuing services to ensure that proper discharge planning/education can be provided by your therapist.

9) Observation(s) of you and or your child's Evaluation and/or treatment session(s) may take place by another therapist, your therapist's supervisor and/or by students in the field or interested in the field.

I have read, discussed, understand and accept the policies as presented here. Upon signing, I agree to comply fully with these policies.

Client ____________________ Date __________

Parent/guardian if client under 18 ____________________ Clinician ____________________ Date __________

(Rev.6/09; Eff 060308)

Inova Loudoun Pediatric & Adult Rehabilitation Center

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Emergency Information

Name: ____

DOB: ___________________________ **SSN:** ___________________________________

Emergency Contact Numbers:

1) Name: _________________________________ Relationship to Patient____________________

Phone #: (Home) ___________________________(Cell) _________________________________

2) Name: _________________________________ Relationship to Patient____________________

Phone #: (Home) ___________________________(Cell) ________________________________

Medical Diagnosis:

Medical History:

Allergies:

Current Medications/Dosage:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Primary Care Physician: ____________________________ **Phone #:** ___________________

Other Relevant Information:

Last Updated: __________
Next Update in 3 months: __________

06/09