Gritman Therapy Solutions
810 S. Main St.
Moscow, ID 83843
Phone: 208-883-1522
Fax: 208-883-6452

Pediatric Intake Form — Feeding Therapy

Child's Legal Name: _____ Child's Nickname: _____
Birthdate: _____ Age: _____ Gender: _____ Today's Date: _____
Primary Care Physician: _____

Parent/Legal Guardian Name:
_____
May we leave a voicemail: ◯ Yes ◯ No
Home Phone: _____ Cell Phone: _____

Physical Address:

Mailing Address (if different):

Employer: _____

Parent/Legal Guardian Name:
_____
May we leave a voicemail: ◯ Yes ◯ No
Home Phone: _____ Cell Phone: _____

Physical Address:

Mailing Address (if different):

Employer: _____

Who else has permission to bring your child to/from therapy sessions?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

My child has permission to join/leave the clinic independently: Yes ◯ No ◯

Legal Guardian Signature: _____

Who is your child's emergency contact?
Name: _____ Relationship: _____
Phone: _____

Home Life:
Primary language spoken in the home: _____
Additional languages: _____
Child resides with: _____
Siblings and/or other children in the home/ages:
_____
If your child attends childcare outside the home, where, and how many hours per week?
_____

If your child attends school, where? _____ Grade_____

Pregnancy and Birth History:
How long was your pregnancy? _____ Birth Weight: _____

Hospital stay after birth? ____◯Yes ____◯No If yes, how long? _____

Did you have a caesarean birth? If yes, please explain:
_____

Were there any complications during the labor or delivery? If yes, please explain:

_____

Current Health:
Current medications: _____
Allergies to medications or food: _____
Any nutritional problems: _____
Additional health concerns: _____

Describe any mental health/behavioral concerns:

_____

Does your child experience pain that impacts their daily function? If yes, please describe:

_____

Past Medical History:

Developmental Milestones (for children 10 and under)
Please note the approximate age your child achieved the following milestones:
Rolled: _____ Sat up alone: _____ Crawled: _____ Walked: _____
Babbled: _____ Said First Words: _____ Put two words together: _____ Toilet trained: _____
Once mobile, how did your child move (crawl, scoot, tripod, quadruped, etc.)?: _____

Please check all that apply

☐Head Injury	☐Allergies	☐Thumb/finger/pacifier sucking
☐Ear Infections/Tubes	☐Constipation	☐Diarrhea
☐Oral/speech problems	☐Hernia	☐Swallowing restrictions
☐Feeding Difficulties	☐Asthma	☐Drug/Alcohol exposure
☐RSV	☐Heart problems	☐Stomach problems
☐Cancer	☐Diabetes	☐Depression
☐Anxiety	☐Skin problems	☐Hearing loss
☐Reflux	☐Motor skill issues	☐Seizures
☐Vision problems	☐Sleep Difficulties	☐Irritable bowel

Please give more details about all areas checked or any other issues not listed:

_____

Has your child had surgery? Do they have an upcoming surgery scheduled? If yes, please explain.

_____

Other Professional(s) working with the patient:

Did/does your child receive early intervention services? If yes, please describe:

_____

Does your child receive school-based services? If yes, please describe:

_____

Optometrist/Ophthalmologist: _____

ENT/Otolaryngologist: _____

Neurologist: _____

Psychiatrist: _____

Orthoptist/Prosthetics: _____

Care Coordinator: _____

Other: _____

Are there any agencies (e.g., child's school, psychologist, etc.) that you would like us to be in contact with? If so, please let us know so we can have you sign a Release of Information._____

Feeding Information:
Please share your concerns about your child's feeding abilities:

_____

Has your child ever been fed /currently being fed by a tube? Yes ◯ No ◯
If yes, what is the schedule? _____

Has your child ever undergone a Modified Barium Swallow Study? Yes ◯ No ◯
If yes, when and where? _____

Does your child have any food allergies/intolerances? Yes ◯ No ◯
If yes, what?_____

Does your child have regular bowel movements? Yes ◯ No ◯

Does your child currently take medication for constipation? Yes ◯ No ◯

Does your child currently take medications for reflux/GERD? Yes ◯ No ◯

Does your child self-feed? Yes ◯ No ◯
Using hands Yes ◯ No ◯
Using utensils Yes ◯ No ◯

Is it hard to tell if your child is hungry? Yes ◯ No ◯

Does your child have a predictable feeding schedule? Yes ◯ No ◯

Does your child's food intake vary from meal to meal? Yes ◯ No ◯

Is your child likely to eat more at one meal than other meals? Yes ◯ No ◯
If so, which meal and why?_____

Does your child eat better for one caregiver or the other? Yes ◯ No ◯
If yes, please specify the individual_____

Does your child refuse to touch certain feed or objects? Yes ◯ No ◯
If yes, please specify: _____

How does your child take liquids? ☐ Breast ☐ Bottle ☐ Sippy Cup ☐ Open Cup ☐ Straw cup

Is your child on formula? Yes ☐ No ☐
If so, what kind and how much during the day?_____

Does your child require his/her liquids to be thickened? Yes ☐ No ☐

How long does feeding take? ☐ less than 15 minutes ☐ 15-30 minutes ☐ 30-60 minutes ☐ More than 60 minutes

What kind/type of foods does your child eat and how frequently does he/she eat it?
using the following as a guide: never, 1-2 times a week = Seldom, 3-4 times per week = occasionally, every day = Always

Food Type	Never	Seldom	Occasionally	Always
Fruits: apples, oranges, bananas, etc. (fresh, frozen, canned, dried)	☐	☐	☐	☐
Grains: Cereal, bread, toast, starches, etc.	☐	☐	☐	☐
Combined foods: soup, lasagna, mac n cheese, pizza, etc.	☐	☐	☐	☐
Fats: butters, oils	☐	☐	☐	☐
Sweets: Cookies, cake, candy, etc.	☐	☐	☐	☐
Protein: eggs, meat, fish, chicken, pork, etc.	☐	☐	☐	☐
Veggies: squash, carrots, peas, etc.	☐	☐	☐	☐
Dairy: milk, yogurt, cheese, etc.	☐	☐	☐	☐
Fluids: juice, soda, sports drinks, etc.	☐	☐	☐	☐
Water	☐	☐	☐	☐

What are your goals for feeding therapy?

_____

What activities does your child enjoy? What are your child's strengths?

_____

Does your child struggle with fine motor tasks (buttons, dressing fasteners, coloring, cutting, etc.)?

_____

Does your child struggle with gross motor tasks (e.g.,appears clumsy, difficulty learning new movements, poor balance)?

_____

Do you have any concerns about your child's sensory processing (sensitivity to light, sound, touch, etc.)?

_____

Has your child experienced any past challenges or traumas you would like your therapist to know about?

_____

Please feel free to update your therapist throughout the therapy experience. We would love to know about your child's passions and successes, no matter how large or small. Is there anything else you would like us to know?

_____

Policy Page – Feeding Therapy

It is important to us that you and your child have a positive experience in therapy. Please initial the following to indicate your understanding of our clinic policies.

_____ Arrive Early:

Initial Evaluations: You are expected to arrive and check-in 15 minutes prior to your scheduled evaluation to allow for the registration process.

Aquatic Patients: Please arrive 15 minutes prior to your scheduled appointment to give you time to change for the pool.

_____ Cancellations:

It is expected that you will provide 24-hour notice when canceling your appointment with the exception of illness. To cancel your appointment, please call (208)883-1522. You can contact us 24 hours a day, 7 days a week. If you reach our answering service, please leave a message. Providing less than 24-hours' notice is considered a No Show.

_____ No Show:

Not providing 24-hours' notice is considered a No Show. If you have not given proper 24-hour notice, with the exception of sickness, we follow the guidelines listed below:

If you No Show your initial evaluation (your 1st appointment with your therapist) two times, your referral will be moved to the bottom of the waitlist. A notification will be sent to your referring provider.

First and Second No Show for Treatment: You will receive a warning notice through OCHIN EPIC MyChart or a phone call (only for those who have not signed up for MyChart), explaining our policy and requesting compliance.

Third No Show/Late Cancelation: A termination letter will be sent to you via OCHIN EPIC MyChart or a phone call/voicemail (for those who have not signed up for OCHIN EPIC MyChart) explaining our policy. Notification will be sent to your referring provider.

_____ Late Arrivals:

If you arrive more than 10 minutes after your appointment time it may necessitate cancellation and/or reschedule the appointment. The Front Office Staff will consult with your therapist to determine if there is time to have an abbreviated appointment.

_____ Illness:

We value the health and safety of our patients and staff. If you or your child have been sick in the past 24 hours (fever, vomiting, cold/flu/COVID like symptoms) please cancel your appointment. Our staff will keep these standards as well and not attend their shift to ensure your health and safety. This may lead to us cancelling your appointment.

_____ Parental Involvement:

You are your child's first and most important teacher. We ask that you to observe all of your child's therapy session(s).

_____ Homework:

We encourage families to practice their therapy exercises at home. Your therapist will provide specific suggestions. If you have questions or are unsure of what to do with your child at home, please do not hesitate to speak with your child's therapist.

_____ Consent:

We will automatically share your child's evaluation and subsequent progress reports with the provider who referred your child to us. If you would like us to share information with your child's school, or another provider, please sign the attached Authorization to Release Protected Health Information.

_____ Insurance:

We will bill your insurance (if applicable) for your child's therapy visits. If you have any questions about your coverage, we encourage you to contact your insurance company. If you have questions about your bill, please contact the Gritman Billing Office.

_____ Email:

Please be aware that MyChart is the preferred and most secure way to communicate with your provider. Email communication is not considered a secure method of transmitting sensitive health information under the Health Insurance Portability and Accountability Act (HIPAA). While we strive to protect your privacy, there is a risk that your information may be intercepted or accessed by unauthorized individuals. By choosing to communicate with us via email, you acknowledge and accept these risks. If you still wish to receive correspondence over email, please confirm your preference below.

Would you like to be contacted over email?: _____

Parent or Legal Guardian Name & Email Address:

_____

Parent or Legal Guardian Name & Email Address:

_____

I have read and understand all the policies stated above.

Printed Name: _____

Signature: _____

Relationship to Patient: _____ **Date:** _____