# St. Joseph's Children's Hospital
# The Pediatric Center for Feeding & Swallowing

**PFC# ________**

**Name: ____________________________ M F**
**DOB: ________________ SS#________________**
**Legal Guardians: ____________________________**
**Phone: (H)________________________________**
**(W)________________________________**
**(C) ______________________________**
**Fax/e-mail: _________________________________**
**Home Address: _____________________________**
**_____________________________**

**Referral: ______________________________**
**Pediatrician: __________________________**
**Peds address:___________________________**
**___________________________**
**Peds phone:_____________________________**

**Describe feeding concerns: ________________________________________ Wt: ______ Ht: ________**
**Diagnoses: ______________________________________________________________________**
**Current Medications: _____________________________________________________________**

**Developmental Issues:** (circle what applies)
cognitive motor speech

**Services:** (circle what applies)
OT PT ST ED ABA Other

**Allergies to foods or medicines:_________________ _______________________________________**
**Immunizations up to date? Y___ N ___If not why _______________________________________**

**Respiratory Issues:** (check ALL that apply)

| | | | |
|---|---|---|---|
| ___ Congestion | ___ Coughing in a.m | ___Coughing after meals | ___ Frequent illnesses |
| ___ Apnea | ___ Snoring | ___ Mouth Breathing | ___ Pneumonia's |
| ___Noisy Breathing | ___ Irreg. Breathing | ___ Grunting | ___ Cyanosis (blueness |
| ___ Trach | ___ Vent | ___ Valve | |

**Gastrointestinal Issues:** (check ALL that apply)

| | | | |
|---|---|---|---|
| ___Gags | ___ Limits intake | | ___ Frequent Diarrhea |
| ___ Wet burps | ___ Vomiting during/ after meals | ___ Stools less than daily | ___Chest/abdominal pain |
| ___ Arching after meals | | ___ Poor wt gain | |
| ___ Pale/lethargic after meals | | | |

___ Tube feeding G, J, GJ, NG Formula/rate/quantity/delivery method ________________________
While having a bowel movement: ___ Cries/grunts ___ Hard/ball-like ___Strains/gets red in face

**Oral-motor Issues:** (check ALL that apply)

| | | |
|---|---|---|
| ___ Poor tongue control | ___ Choking | ___ Gulping air |
| ___ Drooling | ___ Oral defensive | ___ Food from nose |
| ___ Swallowing problem | ___ Chewing problem | ___ Dental problems |

**Mealtime Behaviors:** (check ALL that apply)

| | | |
|---|---|---|
| ___ Food refusal | ___ Aggression | ___ Food selective |
| ___ Grazes | ___ Tantrums | types:_______________ |
| ___ Spitting | ___ Pockets food in cheeks | ___ Prolonged meals |
| ___ Choking | | (______min.) |

Other____________________________________________________________________________

**Insurance Info: Primary**
Co. Name: ______________________________
Policy Holder:___________________________
SS #:___________________________________
ID#: ___________________________________
Grp #: _________________________________
DOB: ___________________________________
Employer Name: _________________________
Employer Address: _______________________
Employer Tel# ___________________________

**(IF) Secondary Insurance**
Co. Name: ______________________________
Policy Holder:___________________________
SS #:___________________________________
ID#:____________________________________
Grp #: _________________________________
DOB:____________________________________
Employer Name:__________________________
Employer Address: _______________________
Employer Tel# ___________________________

**I understand that if I do not obtain a referral, authorization or fulfill any other obligation required by my Insurance Company for any service received by the Feeding & Swallowing Center, that I will be held responsible and will be billed for these services.**

**Name: ________________________________ Signature: ___________________________________**