The Pediatric Feeding Institute of South Florida
7301 W. Palmetto Park Rd, Ste 207-A
Boca Raton, FL 33433
Phone: (561) 571-7557 Fax: (561) 405-9301

Patient Information Questionnaire

Date: _____

Name: _____

DOB: _____ Gender: F M

Pediatrician: _____

Other specialists: _____

Reason for visit: _____

_____

Birth History

Born at: _____

Birth Weight: _____lb. _____ oz.

Gestation: Full Term Premature ____# wks at birth

Apgars: _____at 1 min _____at 5 min _____at 10 min

Birth Complications, if any: _____

_____

Immunizations up to date: YES NO

MEDICAL HISTORY: Hospitalizations, Surgeries, etc

_____

_____

Current Medications, Therapies, Allergies

_____

_____

Hearing Test: Passed at age _____ Not Tested

Vision Test Results: Pass Not Tested Wears Glasses

Social and Environmental History:

Home environment and people involved in child's care:

_____

Language(s) spoken in home: English____ Other _____

Growth and Development

Rolled over at _____ Sat unassisted at _____

Crawled at _____Pulled to Stand at _____

Walked at _____ Babbled at _____

First true word at _____Short Sentences_____

Potty Trained at _____

Eating Concerns: _____

_____

Drinks from: Bottle Sippy Cup Straw Open Cup

Uses: Spoon Fork

Dresses self: Not at All With Help Independently

Undresses self: Not at All With Help Independently

Describe your child's attention and play: _____

_____

Favorite Toys: _____

Describe your child's sleep patterns:

Sleeps through the night Sleeps _____(# of hours)

Position: Back Tummy Side

Describe your child's strengths: _____

_____

How does your child learn most effectively?

Visually Listening Touching/Manipulating

Daycare or School: _____

Teacher: _____ Phone: _____

Signature of person completing the form:

_____

Relationship to Child: _____

Please don't hesitate to call with any questions/concerns
(561) 571-7557
www.pediatricfeedinginstitutefl.com pediatricfeedinginstitutefl@gmail.com

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HISTORY AND FEEDING INTAKE FORM

Please complete the entire form before your initial evaluation.

Child's Name: _____

Today's Date: _____ Date of Birth: _____

Caregiver's Name(s): _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Relationship to Child: _____

Child's Height_____ Weight: _____ Date Taken: _____

Previous Therapy Provider/School: _____

Primary Physician:

_____

Address: _____

City, State, Zip: _____Phone: _____

Pediatric Specialist Physicians: _____

Please check all that apply:

Food Refusal date started: _____

Food Selectivity date started: _____

Oral Motor Delays (drooling, difficulty chewing) Specify: _____

Dysphagia (Choking, coughing with food or liquids) date started:_____

Food Selected by temperature, brand, specific utensil/cup date started: _____

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Please Check for all the foods eaten by your child and family.

FOOD	Child	Family	FOOD	Child	Family	FOOD	Child	Family
Apple			Milkshake			Pork		
Apple juice			Other cheese			Roast Beef		
Applesauce			Pudding			Sausage		
Apricots			Sherbet			Shrimp		
Avocado			Sour cream			Steak		
Banana			Tofu			Tuna Salad		
Berries			Yogurt			Turkey		
Cantaloupe			Crackers			Veal		
Cherries			Fruit Snacks			Chili		
Cranberry juice			Candy			Pot Pie		
Fruit Cocktail			Pie			Soup		
Grapefruit juice			Potato chips			Stuffing		
Grapes			Pretzels			Bagel		
Grape juice			Bacon			Breakfast Bars		
Honeydew			Baked beans			Cereal		
Kiwi			Chicken			Asparagus		
Lemonade			Chicken nuggets			Beets		
Mango			Chicken salad			Broccoli		
Nectarine			Clams			Cabbage		
Oranges			Crab/lobster			Carrots		
Orange juice			Eggs			Cauliflower		
Peaches			Fish			Coleslaw		

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Pear			Fish Sticks			Celery		
Pineapple			Ham			Corn		
Plums			Ham Salad			Creamed Corn		
Prunes			Hamburger			Cucumbers		
Prune juice			Hot Dog			Greens		
Strawberries			Lamb			Green Beans		
Raisins			Lentils			Lettuce		
Watermelon			Liver			Lima Beans		
American cheese			Lunchmeat			Onions		
Cheese spread			Meatloaf			Peas		
Chocolate milk			Other Beans			Green Pepper		
Cottage cheese			Nuts			Pickles		
Cream cheese			Peanut Butter			Spinach		
Ice cream			Peanuts			Squash		
Milk			Popcorn			Sweet Potato		
Cake			Grits			Poptart		
Cheese Puff			Lasagna			Mashed/baked potato		
Chocolate			Ravioli			Potato salad		
Cookies			Macaroni			Ramen noodles		
Corn Chips			Muffins			Rice		
Cream of Wheat			Rolls			Spaghetti		
Donut			Noodles			Taco/burrito		
Egg Noodles			Oatmeal			Waffle		
Farina			Pancake			Wheat bread		
French Fries			Pita			White bread		

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French Toast			Pizza			other		

DRINKING:

Does your child drink from: open cup sippie cup straw bottle

Does your child require a liquid supplement: YES NO

If yes, which one? _____How much/day?_____

What kind of milk does your child consume:
Whole 2% 1% Skim Soy Rice Oat

How many ounces of milk does your child consume in a day? _____

How much juice does your child consume in a day? _____

Does your child drink liquid that contains caffeine? YES NO
If yes, how many ounces each day?____

Does your child drink water? YES NO
If yes, how many ounces each day? _____

What are your goals? Check all that apply.

Increase the volume of food my child eats ___
Increase the variety of food my child eats ____
Improve oral motor skills ____
Decrease gagging/vomiting during meals ____
Other ____

Increase weight gain ____
Improve cup drinking ____
Improve mealtime behaviors ____
Decrease tube dependency ____

Where does your child eat?

_____Caregiver's lap _____Booster Seat _____Infant Seat

_____High Chair _____Chair at table _____Walking _____Other:_____

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What behaviors are seen at mealtime?

_____Throws Food _____Messy Eater _____Leaves Table

_____Spits Out Food _____Refuses to Eat _____Other: _____

_____Cries _____Refuses to Self Feed

How many times in the last week did any of these occur?

How many meals did your child eat without a caregiver?
Never 1-2 3-4 5 or more

How many meals does your child eat with T.V. on?
Never 1-2 3-4 5 or more

How many times did you make a separate meal for child?
Never 1-2 3-4 5 or more

How often did your child request food?
Never 1-2 3-4 5 or more

Please check all that are applicable:

Consistency	Can Eat	Never Tried	Can't Eat
Liquids/soups			
Stage 1-2 baby food			
Stage 3 baby food			
Pureed table food			
Mashed table food			
Regular table food			

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Crispy/Crunchy food (e.g.chip/cracker)			
Soft solids (e.g.banana)			
Other			

Meal Pattern

How long does it take for your child to finish a meal? _____

Describe your child's appetite. _____

Do you praise your child for eating? _____ How? _____

Do you send your child away from the table when they are not eating? YES NO

Do you give your child the option of another food when they refuse what is served? YES NO

Does your child indicate hunger? YES NO How? _____

Tube Feeding

Were any of these ever used? NG tube Nasal cannula Tracheotomy tube G-tube

Type of feeding tube? _____ Type of formula used? _____

How many calories does your child consume each day? _____

Does your child receive any other liquid/food through their tube? YES NO

If yes, what? _____

Does your child require: Continuous feeding YES NO How much/hour?
_____

Bolus Feeds: What is the schedule? _____

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Volume/bolus_____ How long does feeding take? _____

Does your child gag/vomit during tube feedings? YES NO

If yes, how often? _____

Does your child have a Nissen Fundoplication? YES NO

Please check all that apply. My child experiences problems with:

_____Constipation _____Diarrhea _____Sleeping

Describe: _____

_____

_____

Please check all that apply

___Poor tongue control	___Poor lip control	___Swallowing problems
___Teeth grinding	___Coughing/gagging	___Problems with biting
___Lack of chewing	___Hypersensitive	___Drooling
___Poor Sucking	___Vomiting	

Other: _____

Does your child have a diagnosis? _____

Diagnosis			Food Allergies	Yes	No
Autism, PDD	Yes	No	Lactose Intolerant	Yes	No
Developmental Delay	Yes	No	Vision Impairment	Yes	No
ADHD	Yes	No	Hearing Deficit	Yes	No
Chromosomal Anomaly	Yes	No	Delayed Gastric Emptying	Yes	No
Traumatic Brain Injury	Yes	No	G-tube/J-tube dependency	Yes	No
Anxiety/OCD	Yes	No	Heart Problems	Yes	No

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Spina Bifida	Yes	No	Asthma	Yes	No
Cerebral Palsy	Yes	No	Oxygen dependent	Yes	No
Cleft Lip/Palate	Yes	No	Tracheotomy	Yes	No
Seizure Disorder	Yes	No	Learning Disability	Yes	No
Diabetes	Yes	No	Sensory Integration Dysfunction	Yes	No
Prematurity	Yes	No	Chronic Constipation	Yes	No
Reflux	Yes	No	Chronic Diarrhea	Yes	No

Other: _____

Please list all medications your child is taking: _____

_____

Please list all allergies: _____

Feeding Skills: Check all that apply.

_____ Drinks from bottle _____held by caregiver _____independently

_____Self feeds with fingers

_____Uses a spoon _____with assistance _____independently

_____Uses a fork _____with assistance _____independently

_____Drinks from open cup _____with assistance _____independently

_____Drinks from sippie cup _____with assistance _____independently

Hand preference: Left Right

Positioning/Seating

Is your child in a wheelchair or an adaptive seat? YES NO

Please describe: _____

How much of the day does your child spend in this chair? _____

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Do you have a separate feeding chair? YES NO

If yes, describe: _____

Self Care

___Puts on clothes independently ___Puts on clothes with assistance
___Takes off clothes independently ___Takes off clothes with assistance
___Tolerates brushing teeth (describe: _____)
___Manages fasteners independently (button, zipper, tie shoes)
___Manages fasteners with assistance (button ,zipper, tie shoes)

Fine Motor

___Scribbles ___Imitated Shapes/Lines ___Cuts with Scissors ___Stacks Blocks

Sensory

___Becomes upset with loud noises ___Tolerates hands being messy

___Clumsy/Accident Prone ___Seeks Movement

Please use this space to tell us about your child _____

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PAYMENT POLICY

The Pediatric Feeding Institute of South Florida, is an OUT OF NETWORK PROVIDER, and as such:

Pediatric Feeding Institute of South Florida, LLC, will bill your insurance company as a courtesy to you; however, Insurance coverage is an agreement between you and your insurance company. You will have an out of network deductible to meet before your insurance starts reimbursing for services. You will be asked to pay your estimated payment/co-pay each visit, with the understanding that whatever your insurance does not pay will be your responsibility. You are responsible for your child's evaluation and therapy charges even if your insurance has promised payment and then denies such benefit.

Pediatric Feeding Institute of South Florida can help you keep track of your child's allowed yearly therapy visits with insurance. Most insurance companies allow a certain amount of Speech and OT visits. Often these visits are counted as combined. We can only keep track of the visits your child receives while at the Pediatric Feeding Institute of South Florida. It is your responsibility to keep track and let us know when you are close to the end of your allowed number of visits.

PLEASE READ BELOW AND CHOOSE THE OPTION THAT BEST FITS YOUR NEEDS:

_____OPTION 1: We will collect your estimated payment/co-pay accordingly to what the insurance reimburses at each session. You are responsible for the difference between what your insurance company pays and your therapy session rate.

_____OPTION 2: PRIVATE PAY not using insurance benefits

Any outstanding account balances will be charged to the credit card on file if no payment is received within 30 days of receiving the emailed invoices or if your account balance reaches $500.

I HAVE READ AND UNDERSTAND THE BILLION OPTIONS ABOVE AND CHOOSE OPTION _____AS MY BILLING PROCEDURES WITH PEDIATRIC FEEDING INSTITUTE OF SOUTH FLORIDA.

CHILD'S NAME: _____

PARENT'S NAME: _____

EMAIL ADDRESS FOR INVOICES: _____

Parent's Signature: _____

Date: _____

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CANCELLATION/NO SHOW POLICY

We believe the success your child will achieve while enrolled in our feeding program begins with the consistency of treatment. Therefore, we are committed to doing our best to be here for your child on a consistent basis. If your child is recommended for outpatient therapy, he/she will attend therapy 1-5 days per week, with re-evaluation every 6 months. Your child's attendance and your participation is crucial to making positive, long- lasting outcomes.

We have adopted a standard 24-hour cancellation policy and we understand that life-events require you to miss periodic therapy sessions. **Please contact us (561) 571-7557 or email us to cancel any scheduled appointments you cannot make, at least 24 hours in advance, to avoid a cancellation fee for missed appointments or from being removed from the schedule.**

Cancellation Fee Schedule:

_____**ANY** cancellation with less than 24-hours notice will result in a cost of $25.00/ discipline (feeding, occupational, speech therapy). The credit card on file will be used for this payment. Date: _____

_____Cancellation charges **cannot** be billed to your insurance company and are your responsibility. Fees must be paid before the next treatment session.

NO EXCEPTIONS

It is important to note that when you give us enough notice, we can offer your appointment to another child who needs to be treated. In the case where your therapist has to miss a therapy appointment, we will make every effort to make that session up another day or time that is convenient for your family

Child's Name: _____

Parent's Name:_____

Parent's Signature: _____

Date: _____

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NEW CREDIT CARD ON FILE AGREEMENT

We have implemented a new policy which requires The Pediatric Feeding Institute of South Florida, Inc patients to keep a credit card on file for payment purposes. We have a system which enables us to maintain your Credit Card information securely on file and which can only be accessed under the terms you specify below. By providing us with your credit card information, you are giving Pediatric Feeding Institute of South Florida, Inc. permission to automatically charge your credit card for the amounts due for therapy services received as follows:

Please Initial that you have read the following statements:

_____Your credit card will be charged on a daily basis for the outpatient program if payment is not made by you on the day of your services.

_____Your credit card will be charged at the start of each week, on a weekly basis, for the intensive feeding day program if payment is not made by you at the beginning of each week of the program.

_____Your card will also automatically be charged if your account balance reaches $500 or more.

These payments will match the patient's responsibility amounts as determined by your insurance company and are reflected on the explanation of benefits (EOB's) from the insurance company.

_____Any canceled or missed appointments without a 24-hour notice will result in the credit card on file being charged accordingly (See cancelation policy)

If the credit card information we have on file changes for any reason, please notify Pediatric Feeding Institute of South Florida, Inc. as soon as you can. If you have any questions about a charge, please notify us. ***After 15 days, all charges will be assumed to be correct.*** We will maintain clear record of all payments and charges. However, in the rare case that an overpayment occurs, your account will be credited and applied to your upcoming sessions. A receipt will be emailed to you. You may also ask to receive a paid invoice from Pediatric Feeding Institute of South Florida, Inc., showing your payment.

In the event of a declined charge, you will be asked for a new credit card number and/or payment before continuing treatments.

I HAVE READ AND UNDERSTAND THE CREDIT CARD ON FILE AGREEMENT AND AUTHORIZE PEDIATRIC FEEDING INSTITUTE OF SOUTH FLORIDA, INC TO CHARGE MY CREDIT CARD AS STATED ABOVE.

(circle one) VISA MASTERCARD AMEX DISCOVER **CARD#:** _____

EXP DATE: _____/_____ SECURITY CODE/CID #: _____BILLING ZIP CODE: _____

NAME AS APPEARS ON CARD: _____Child's Name: _____

BILLING ADDRESS ON CARD: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL ADDRESS TO SEND RECEIPTS TO: _____

Parent's Signature: _____ **Date:** _____

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AUTHORIZATION TO RELEASE INFORMATION TO OR FROM THE PEDIATRIC FEEDING INSTITUTE OF SOUTH FLORIDA

Name of Child: _____ **DOB:** _____

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information for payments or administrative purposes as it relates to treatment.

I understand that I have the right to know at all times what information is shared regarding myself or my child. I understand that the identity of the designated parties must be verified before the release of my information. I know that I have the right to revoke this authorization at any time in writing.

This information is required to send the evaluation to the physician and authorize treatment for insurance purposes*

Name of Physician(s): _____

Purpose: _____

*****This information is required if you would like us to have contact with your child's therapists, teachers, etc. before, during and/or after the program*****

Name of Individual(s) sending/receiving information: _____

Type of Information released: _____

Parent Signature: _____

Print Parent Name: _____ Date: _____

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VIDEO AND PHOTO RELEASE

The Pediatric Feeding Institute of South Florida, Inc.'s therapists, Andrea Alifano, M.S., CCC-SLP and Taylor Thomas, M.A., CCC-SLP, frequently present continuing education seminars to speech-language pathologists, occupational therapists, and ABA therapists, advancing their education and clinical expertise in the area of pediatric feeding and swallowing disorders, as well as present to doctors in the area the effectiveness of an intensive therapy approach. These continuing education courses and presentations to doctors often incorporate photographs and videos taken during sessions here at the Pediatric Feeding Institute of South Florida, Inc. We are requesting your permission to photograph/videotape evaluations and/or therapy sessions involving your child to be used solely for educational or promotional purposes.

We sincerely appreciate your collaboration.

I, _____, hereby give my permission for **The Pediatric Feeding Institute of South Florida, Inc.** to videotape and/or photograph my son, daughter, or child under my care for the purposes of professional advancement, education and/or promotion.

I hereby release all rights to such photographs or videos to **The Pediatric Feeding Institute of South Florida, Inc.,** and relinquish all rights to claim any reimbursement of these photographs. I waive my right to inspect or approve the finished photographs or printed matter that maybe used in conjunction with them now or in the future.

I hereby release Pediatric Feeding Institute of South Florida, Inc., the photographer, their offices, employees, agents, and designees from liability for any violation of any personal or proprietary right I may have in connection with such use.

SIGNATURE: _____

CHILD'S NAME: _____

PRINTED NAME SIGNED ABOVE: _____

Relationship to the person photographed or videotaped: _____

Today's Date: _____

WITNESS: _____

The Pediatric Feeding Institute of South Florida, Inc.'s staff will advise you if/when your child/children's photograph is used for one or more purposes detailed above. We understand if you DO NOT feel comfortable allowing Pediatric Feeding Institute of South Florida, Inc. to video or photograph your child at this time. Thank you!

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