Phone: 505-272-3167
Fax: 505-272-9014
HSC-NMSAFE@salud.unm.edu

CENTER FOR DEVELOPMENT & DISABILITY

# NM SAFE CLINIC INTAKE

*Please complete the following questions. You may leave items blank or respond "NA" if you do not have information. We will schedule the NM SAFE appointment when this intake is returned.*
*Please contact us if you need assistance*

**Child's Name (first,middle,last)**: _____

Date of birth: _____ Age: _____

**Parents/Caregivers:** *Please include legal guardian, and caregivers that CDD staff can contact about this referral.*

| | | | |
|---|---|---|---|
| Name | | Name | |
| Relationship | | Relationship | |
| Primary Language | | Primary Language | |
| Mailing address | | Mailing address | |
| | | | |
| Phone numbers | | Phone numbers | |
| | | | |
| E-mail | | E-mail | |

*If child is in CYFD custody, please provide copy of any court documents (e.g., ex parte order), and have CYFD worker sign all consents and release forms.*

| CYFD Social Worker/contact | *Phone* | *Email* | *Fax* |
|---|---|---|---|
| | | | |

Pediatrician/Primary Healthcare Provider(PCP) Name: _____

PCP Address: _____ Phone: _____

What is your main concern about feeding? Please explain reasons for this evaluation:

**Name of person filling out this form:**

**Date Completed**:

**What is your relationship to the child?**

**Phone Contact**: Home: Cell:

Email:

**Who referred you to NM SAFE?**

**Birth History:** ☐ *Unknown*
Type of delivery: ☐ Vaginal ☐ C-section Birth weight:
Place of Birth:
Born on time? ☐ Yes ☐ No ☐ Early: ☐ Late: Weeks late?
Were there any problems or hospitalizations after birth? ☐ Yes ☐ No
If yes, please explain:

**Medical History:**
List any medical conditions/diagnoses (include history of ear infections, acid reflux, GERD, aspiration pneumonia):

Have there been **any recent** problems or hospitalizations? ☐ Yes ☐ No
*If yes, please explain*:

Has your child ever had a **Swallow Study**? ☐ Yes ☐ No
*If yes:* Where: Date of study:
*Please provide a copy if you have the report.*

**Does he/she have any food allergies/intolerances *(e.g., lactose, gluten)***? ☐ Yes ☐ No
*If yes, please explain/list*:

**Is he/she followed by a nutritionist or dietitian?** ☐ Yes ☐ No
Name: _____ Telephone: _____ Email: _____

**Date of height and weight measurement**: _____
Height: _____ Weight: _____ Length (if 3 years old or less): _____

**Is he/she followed by a *dentist*?** ☐ Yes ☐ No
How are his/her teeth and gums?

Has he/she had a recent change in their eating pattern or weight? ☐ Yes ☐ No
If yes, please explain:

*Please list any medications, vitamins, and supplements your child takes on a regular basis:*

| Medication or supplement | Dose (amount of medication) | How often? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Early Eating History:**

- Breast fed? ☐ Yes ☐ No How long?
- Bottle fed? ☐ Yes ☐ No How long?
- At what age did he/she start eating baby food? (Years, months)
- At what age did he/she start table foods? (Years, months)
- Have you observed regression (loss of feeding skills)? ☐ Yes ☐ No
  At what age? (Years, months)

**Check the statements that describe your child's feeding behavior currently:**

| | | | |
|---|---|---|---|
| ☐ | Dependent on gastrostomy tube | ☐ | Cannot or does not chew foods |
| ☐ | Does not eat enough healthy foods | ☐ | Eats too much |
| ☐ | Does not eat any food | ☐ | Eats mostly junk foods |
| ☐ | Has inappropriate behavior at meals | ☐ | Cries and tantrums at meals |
| ☐ | Does not swallow food | ☐ | Does not swallow liquids |
| ☐ | Is not growing properly | ☐ | Pockets/holds food in mouth/cheeks |
| ☐ | Spits out foods or liquids | ☐ | Does not remain seated for mealtime |

Does your child feed himself/herself? ☐ Yes ☐ No

- What does he/she use to eat? ☐ fingers ☐ spoon ☐ fork
- What does he/she use to drink? ☐ cup ☐ sippy cup ☐ straw ☐ bottle ☐ G-tube
- ☐ Other:
- How much liquid does he/she drink daily _____
- What liquids does he/she usually drink? _____

| Do any of the following occur *during or after* eating? | Check all that apply | Please describe |
|---|---|---|
| a. Indigestion/Nausea/Vomiting | ☐ | |
| b. Constipation | ☐ | |
| c. Diarrhea | ☐ | |
| d. Pain | ☐ | |
| e. Spitting out food | ☐ | |
| f. Drooling | ☐ | |
| g. Gagging | ☐ | |
| h. Choking | ☐ | |
| i. Coughing | ☐ | |
| j. Gurgly/wet voice | ☐ | |

What *types* of food does he/she eat?

| **Food** | **Check all that apply** | **Consumed in the past, not currently** |
|---|---|---|
| Liquids | ☐ | ☐ |
| Strained baby foods | ☐ | ☐ |
| Yogurt/pudding texture | ☐ | ☐ |
| Oatmeal cereal texture | ☐ | ☐ |
| Junior or ground foods | ☐ | ☐ |
| Fork mashed table foods | ☐ | ☐ |
| Soft finger foods | ☐ | ☐ |
| Cookies/crackers | ☐ | ☐ |
| Coarsely chopped table foods | ☐ | ☐ |
| Table foods | ☐ | ☐ |
| Easily chewed meats | ☐ | ☐ |
| Chewy meats | ☐ | ☐ |
| Crunchy foods | ☐ | ☐ |
| Mixed texture | ☐ | ☐ |

What foods does he/she eat? (i.e., preferred foods) *Please list*

What does he/she NOT eat? (i.e., non-preferred foods) *Please list*

How does your child tell you that he or she is hungry?

My child's appetite is:

| | | | | |
|---|---|---|---|---|
| Poor ☐ | Fair ☐ | Good ☐ | Excellent ☐ | Irregular ☐ |

Please check the boxes that show how long it takes your child to eat each meal:

| | 0-10 minutes | 11-20 minutes | 31-40 minutes | 41-50 minutes | 51+ minutes |
|---|---|---|---|---|---|
| Breakfast | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lunch | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dinner | ☐ | ☐ | ☐ | ☐ | ☐ |
| Snack | ☐ | ☐ | ☐ | ☐ | ☐ |

How long does your child go between meals and/or snack time (from start of one meal to start of next)?

What type of seating is used for your child at mealtime:

- ☐ High chair
- ☐ Booster seat
- ☐ Chair at table
- ☐ Other:

Does your child typically stay seated during meals? If yes, for how long?

| Meal | Does your child eat with the family? | | Where does your child: | | Supports: Special things you do before or during the meal (i.e., turn on tv, give child Ipad, use special utensils, etc) |
|---|---|---|---|---|---|
| | Yes | No | Eat (room) | Sit (chair) | |
| Breakfast | ☐ | ☐ | ☐ | ☐ | |
| Lunch | ☐ | ☐ | ☐ | ☐ | |
| Dinner | ☐ | ☐ | ☐ | ☐ | |
| Snack | ☐ | ☐ | ☐ | ☐ | |

**Education & Services**

Has your child received a developmental or educational evaluation? ☐ Yes ☐ No

If Yes, when/where? _____

*Please send copy of evaluation report(s) when you return this form.*

**What therapy services is your child receiving?**

☐ **SLP** Name: _____
Phone: _____ Agency: _____

☐ **OT** Name: _____
Phone: _____ Agency: _____

☐ **PT** Name: _____
Phone: _____ Agency: _____

☐ **ABA** Name: _____
Phone: _____ Agency: _____

☐ **Other** Name: _____
Phone: _____ Agency: _____

☐ **Case Manager/ Family Service Coordinator (EI):** Name: _____
Phone: _____ Agency: _____

## School services:

School District: _____ Current Grade: _____

Type of classroom: ☐ General education ☐ Inclusion ☐ Special education services

If child receives special education services, how many hours per day does he/she spend in general education? _____

**Who lives at home with your child?**

| Name | Age | Relationship | Primary Language |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Developmental Milestones**

| When did your child first do the following? | Age | Not Yet | Not Sure |
|---|---|---|---|
| Rolled over | | ☐ | ☐ |
| Sat without help | | ☐ | ☐ |
| Crawled on hands and knees | | ☐ | ☐ |
| Walked without help | | ☐ | ☐ |
| Said single words | | ☐ | ☐ |
| Used two or more words | | ☐ | ☐ |
| Talked in short sentences | | ☐ | ☐ |

**Any additional concerns, comments or information you would like us to know?**