Building Bridges
THERAPY CENTER

Welcome,

Thank you for choosing *Building Bridges Therapy Center*. Here is what to expect as you begin services with us. We begin with an evaluation so that we understand your child's needs as well as strengths. Therapy goals and/or recommendations are then created for your child. We utilize a variety of assessments and treatment procedures to provide a customized plan for learning. We believe in collaborating with parents and other professionals both at Building Bridges and elsewhere, because shared knowledge leads to the best therapy. All our therapists are certified or licensed and qualified in their respective fields.

Our goal is to provide excellent care. If you have any questions or concerns regarding your services, please make your therapist aware—they look forward to working closely with you. Additionally, please feel free to contact me anytime, you can reach me at jpagano@bridgestherapy.com or 734-372-1965.

Welcome to Building Bridges!

Sincerely,
Janice Pagano, M.A., CCC-SLP
Clinical Director

Building Bridges
THERAPY CENTER

REGISTRATION for INSURANCE COVERAGE: SPEECH, OT, PT, FEEDING

To get started, ALL the below information must be completed and received in our office in order to receive a call to schedule your child's therapy session(s).

- **Complete our welcome packet**
- **Make a copy of your insurance card (front and back)**
- **Make a copy of your driver's license (front and back)**
- **Obtain a Doctor referral/script (the following needs to be included):**
  - Date
  - Child's name
  - What therapy your child will be attending
  - Evaluation and treatment 1-2x/wk
  - Diagnosis Code (ICD 10)
  - Doctors name, signature and NPI #
- **If your child had a Speech, Occupational Therapy, Physical Therapy and/or Psych evaluation this year, please include a copy of the report with your completed welcome packet.**

- **When you have all of the above information**, please scan/email, fax, mail or drop off to:
  - Building Bridges Therapy Center
    46200 Port Street
    Plymouth, MI 48170
  - Fax# 734-454-1744
  - office@bridgestherapy.com

- Our Client Service Specialist will contact you within 2 weeks after receiving ALL of the information to schedule your child's therapy session(s). If you do not hear from us, please contact us at 734-454-0866 or at office@bridgestherapy.com.

- Please contact your insurance to verify benefits. An insurance verification form is included in the welcome packet. For more information regarding insurance, please see our website at www.bridgestherapy.com.

Building Bridges
THERAPY CENTER

CLIENT INFORMATION

Today's Date _____/_____/_____

CHILD'S INFORMATION

Child Name: _____ Sex:_____

Date of Birth ____/____/____

Address _____ City _____ State____ Zip _____

Primary Care Provider: _____

PARENT/GUARDIAN'S INFORMATION

Parent/Guardian Name: _____ Sex:_____

Address (if different from above) _____

Phone #'s (indicate primary) Home_____ Cell(mom)_____Cell(dad)_____

Work(mom)_____Work(dad)_____

Email: _____ **Soc Sec #** _____

We require a parent's social security number. This is for delinquent account purposes only. If you do not wish to provide a parent's social security number we require payment at the time of each service. Please check in with the office to submit payment before each of your child's scheduled therapy appointment(s).

INSURED'S INFORMATION

Insured's Name: _____ Sex:_____

Address (if different from above) _____

Employer Name and Address _____

Phone #'s (indicate primary) Home_____ Cell_____ Work_____

Insurance Company _____ Policy #: _____ Group#_____

Email:_____ **Soc Sec #** _____

We require the primary insured parent's social security number. Since payment cannot be made the same day of service for insurance clients, the insured's social security number is a requirement with no exceptions.

Whom can we thank for referring you to Building Bridges?

◯ Dr: _____

◯ Friend: _____

No referral; we found Building Bridges through ...

◯ Social Media

◯ Internet Search

◯ Other: _____

Building Bridges
THERAPY CENTER

PAYMENT POLICY

Thank you for choosing Building Bridges Therapy Center…we welcome you to our clinic. Our goal, first and foremost, is to provide you with the highest quality care. Following is our payment policy, which enables us to best focus our resources on providing services. Please review carefully, and return a signed copy prior to your child's first therapy session.

1. Each client is solely and individually responsible for all fees for services provided. It is up to the client to determine if therapy is a covered benefit under his or her particular plan. Clients' contracts with their insurance company are agreements between the clients and insurance company, and we are not a party to it. We urge clients to check the particulars of their policy prior to beginning treatment.
2. In the event that an outside organization or agency fails to provide the planned payment for your services for any reason, the client is solely and individually responsible for all fees for services provided.
3. Each client must establish a weekly or monthly payment schedule. Bills are sent at the end of each month. Note that certain programs may have an established payment schedule; if this is the case, clients will be informed of the applicable payment schedule.
4. All initial evaluations are to be paid on the date of service.
5. Payment can be made by cash, check or credit card. Payments can be made directly at the front office or left in the locked payment drop box through the window to the front office.
6. Please note that there is an Attendance policy (enclosed). Under this policy, if a client is a no show / late cancellation, the client may be charged 50% of the scheduled therapy fee to compensate the therapist for preparation and wait time. In situations of an emergency or illness, the above fee will not apply. If a client is late for a therapy session, the client is responsible for the fee for the entire scheduled session.
7. Prior to the last scheduled day of services, accounts must be paid in full or an alternate payment plan must be established.
8. In situations of divorce, separation, or other situations of shared custody, the adult who signs this policy shall be responsible in full for payment.
9. I agree, in order for Building Bridges Therapy Center to service my account or to collect any amounts that are due, Building Bridges Therapy Center and debt collection service providers may contact me by telephone at any telephone number or email address associated with my account.
10. In the event that: (a) no payment is made by a client receiving ongoing services for over sixty (60) days, or (b) that an account is not paid in full by the last day of services, Building Bridges Therapy Center reserves the right to assess a 2.0% late penalty per month from the last date of zero balance until the account is paid in full. This charge is to offset the cost and efforts required for collection of extremely delinquent accounts and to encourage timely payment of accounts.
11. The terms of this payment policy apply for all services currently being provided to as well as any future services provided by our clinic.
12. Building Bridges Therapy Center reserves the right to modify or replace this policy at any point in the future. Clients will be notified of any such changes.

We recognize that therapy services, while often essential to your child's development, are costly. If the financial considerations are prohibitive, please speak with Lauren Macuga to see if you are eligible for alternative arrangements. It is our desire to provide services to all who would benefit from them.

I have read this policy and consent to its terms and provisions. I agree to pay for services on a weekly/monthly schedule, or according to any established payment plan that may be applicable. I understand that I am directly responsible for payment for services, and that it is my responsibility to submit any claims to my insurance company for reimbursement.

Child Name _____ **Parent Name** _____

Parent Signature _____ **Date** _____

Building Bridges THERAPY CENTER

INSURANCE VERIFICATION

We urge you to call and verify your benefits before your child begins therapy. It is extremely important to understand your deductible amount, out of pocket maximum cost, co-payment/co-insurance and visit limitations. Building Bridges only receives limited information regarding your insurance plan.

- What is your primary health insurance company? _____
- Please indicate if you have a secondary insurance company_____
- Effective date: Primary_____ Secondary_____
- Co-pay: Primary_____ Secondary_____
- Co-Insurance: Primary_____ Secondary_____
- Deductible: Primary_____ Secondary_____
- Out of Pocket Max: Primary_____Secondary_____
- Is Autism a benefit covered under your insurance plan? YES NO
- If yes, do visit limitations apply? YES NO
- Visit Limitations per year:
  - Primary Insurance: ____Speech ____OT ____PT ____Psych
  - Are your Speech, OT, PT visit limitations combined per year? YES NO
  - If yes, # of visits:_____
  - Secondary Insurance: ____Speech ____OT ____PT ____Psych
  - Are your Speech, OT, PT visit limitations combined per year? YES NO
  - If yes, # of visits:_____
  - Do 2 or more therapy sessions in one day count as 1 visit? YES NO
  - Is an authorization required? _____Speech _____OT _____PT _____Psych
- Has your child had an evaluation this year for: _____Speech _____OT _____PT _____Psych
  - If yes, Insurance may not pay for a 2nd evaluation in a year. Please include evaluation report with your welcome packet.

Insured's Signature_____ Date:_____

Print Name_____

THERAPY VISIT TRACKING

As you are aware, your insurance plan may only allow a certain number of therapy visits per year (visit limitations). This includes any therapy services at Building Bridges Therapy Center, as well as any other facility. Please keep track of your visits, this is your responsibility.

- Once you have reached your visit limitation for your plan year, please notify us.
- You may then continue therapy at our private pay rate or discontinue therapy until new plan year.

_____initial

INSURANCE CHANGES

Please inform us immediately if any part of your insurance changes or if you have a new health insurance. Verification of your benefits will need to be completed before continuing therapy.
Often insurance companies require pre-approval or authorization. They may not retro-date authorizations, which may result in a period in which you are personally responsible for payment for services.

_____initial

Building Bridges
THERAPY CENTER

Non-Covered Services Consent

It is recognized that patients might request non-covered and/or non-authorized services that are, therefore, payable by the patient's family. By signing below, I acknowledge that I am aware of such non-covered and/or non-authorized services and that my insurance company will not be responsible for the cost of such services.

Child Name _____ **Parent Name** _____

Parent /Guardian Signature_____ **Date** _____

Building Bridges
THERAPY CENTER

ATTENDANCE POLICY

Our office should be notified 24 hours in advance when a child cannot keep a scheduled therapy appointment other than for illness or emergencies.

Recurring *No Shows, late cancellations* and/or *late arrivals and late parent pick-ups* are subject to fees. Parents will be provided with a warning before these fees are incurred.

If there are more than 6 late arrival/pickups or no shows in any 12 month period, this will result in the discontinuation of services. Any potential discontinuation will first be discussed with the parent.

FEES:

- Recurring No Shows, late cancellations and/or late arrivals and late parent pick-ups or chronic cancellations may result in a charge of 50% of the therapy fee.
- If you have an outside source of funding such as an insurance company, these fees will be charged directly to you and not the outside agency.
- We will send an invoice to you once fees have incurred.

NOTICE FOR SPEECH-LANGUAGE THERAPY
30-MINUTE SESSIONS ONLY

For BCBS, BCN, Priority Health, Aetna.
Please be aware that we are unable to bill insurance if you are more than 7 minutes late for a 30-minute speech-language session. If you are more than 7 minutes late we can either bill you directly at our private pay rate of $64.00 or you can choose to not have your child seen that day.

Our staff is dedicated to work diligently to help your child reach his/her fullest potential. We ask your cooperation in helping us achieve that objective. If you have any questions, please do not hesitate to speak to the office or Clinical Director. We appreciate your cooperation in this matter.

X_____ I have read this letter and agree to the terms stated above.

Building Bridges

HEALTH POLICY

Staff, parents, clients and siblings are advised not to come to the clinic or sit in the waiting room when the following conditions are present:

- Oral temperature of 100.5 or higher
- Intestinal problems with diarrhea or vomiting
- Any type of undiagnosed rash
- Any type of communicable illness (chicken pox, measles, impetigo, pink eye, strep throat, etc.)
- Congestion or mucous discharge of the eyes, nose or ears
- Body aches, headache, and feeling very tired
- Persistent cough, sore throat

Anyone presenting with these symptoms will be asked to leave the clinic or waiting room.

A sick individual should not return to the clinic until he or she:

- Has been free of a fever (100.5 or greater) for at least 24 hours without the use of fever reducing medications.
- Has been free of vomiting, diarrhea, rash, eye, ear and nasal drainage for at least 24 hours
- Has received antibiotics for strep throat or medicated eye drops for the treatment of pink eye for a minimum of 24 hours
- An individual with chicken pox may not return to the clinic until 1 week after the eruption of first crop of lesions and after all lesions have crusted

We encourage staff and families to:

- Wash hands often with soap and water or an alcohol-based hand rub
- Cover coughs and sneezes with tissues or use elbow, arm, or sleeve instead of a hand when tissue is not available
- Know the signs and symptoms of the flu
- Report cases of flu or other communicable illness to Building Bridges staff within 24 hours of the last clinic visit
- Be cautious and keep potentially sick individuals at home

X _____

I have read this letter and agree to the terms stated above.

Thank you for your cooperation.

Building Bridges
THERAPY CENTER

OPTIONAL

MONTHLY RECURRING Credit Card Authorization Form

THIS CREDIT CARD IS A: ❑ VISA ❑ MASTERCARD

CREDIT CARD NUMBER: Full card number: _____

EXPIRATION DATE: _____

CARD SECURITY CODE (CV2): _____

NAME (as it appears on the credit card): _____

BILLING ADDRESS (must be the exact billing address as it appears on the Credit Card Statement):

_____
Address

_____ _____ _____
City State Zip

I authorize Building Bridges Therapy Center (BBTC) to charge my credit card **monthly** for payment of services for the child listed. If BBTC is unable to process my payment I will be responsible for an alternate payment arrangement and any resulting processing fees that may be incurred. This authorization is in effect until I notify them otherwise in writing. I understand that all expenses will be charged on my behalf and these may include additional charges from any previous months.

By signing this authorization, I acknowledge that I have read and agree to all of the above information and warrant all information provided is true and correct.

THIS AGREEMENT REMAINS IN EFFECT UNTIL CANCELED BY THE APPLICANT WITH WRITTEN NOTICE. This agreement may be cancelled by the applicant by providing BBTC a written notice at least 30 days in advance of the cancellation date.

Applicant's Name (print): _____

Applicant's Signature: _____ Date: _____

Child's Name: _____ Account Number: _____

Building Bridges
THERAPY CENTER

THERAPY AVAILABILITY FOR
SPEECH, OCCUPATIONAL THERAPY, PHYSICAL THERAPY, MUSIC THERAPY

Child's Name_____

Therapy	Speech	OT	PT	Music
Circle one	1x or 2x	1x or 2x	1x or 2x	1x or 2x
Circle one	30 min 45 min 60 min	30 min 45 min 60 min	30 min 45 min 60 min	30 min 45 min 60 min

Availability:
My child is available for therapy at the following times:
(Please indicate day of the week and mark preferred times with a "P" and any additional availability with an "A.")

Day	Mon	Tues	Wed	Th	Fri	Sat
8 a.m. – 12 pm						
12 – 4 pm						**Not available**
After 4 pm					**Not available**	**Not available**

If your child will be receiving more than one therapy service, do you prefer to have therapy back to back?
YES NO

If yes, we will try our best to accommodate.

Building Bridges
THERAPY CENTER

MEDICAL INFORMATION

Client's Name: _____ Date of Birth: _____

Mother's Name: _____ Father's Name: _____

Address: _____ City_____ State____ Zip Code_____

Home Phone Number: _____ Parent Work Number:_____

Alternative Phone Number: _____ E-mail:_____

In case of an emergency, please contact:

Name: _____ Phone Number:_____

Alternative Phone Number: _____

Relationship: _____

Allergies: yes/no

If yes, please list allergies: _____

_____

Dietary considerations: yes/no

If yes, please list: _____

_____

Medications: yes/no

If yes, please list medications: _____

_____

Special Instructions: _____

Health Conditions: yes/no

If yes, please state condition and describe intervention that may be required by our staff during therapy, for example, epee pen or seizure medication: _____

_____

In an emergency, I authorize Building Bridges Therapy Center to obtain emergency medical treatment, if the parent is not immediately accessible.

_____ _____

Parent Name (print) Parent Signature Date

CONFIDENTIAL: Not to be re-released without express written

Building Bridges

CONFIDENTIAL EXCHANGE/RELEASE OF INFORMATION FORM

CLIENT NAME: _____ **DOB:** _____

Date this form was reviewed/given to parent/guardian: _____

Building Bridges requests parent/guardian permission to exchange information with the provider listed in the right column of this form.

A. BUILDING BRIDGES PROVIDER INFORMATION

Provider Name: _____

Address: 46200 Port St., Plymouth, MI 48170

Phone: 734-454-0866 Fax: 734-454-1744

Email: _____

MODES OF COMMUNICATION

(Check all modes of communication that you agree to)

☐ **All modes of communication listed**

☐ Phone ☐ Email ☐ Fax

☐ In person ☐ Mail ☐ Drop off/Courier

INFORMATION/DOCUMENTS THAT BUILDING BRIDGES CAN SHARE WITH OTHER PROVIDER:

☐ Diagnostic Evaluation Report(s)
☐ Treatment Assessment Report(s)
☐ Treatment Recommendations
☐ Progress Report(s)
☐ Discharge Summary
☐ Other (specify): _____
_____
_____

☐ IFSP/IEP (most current)
☐ CMH Personal Plan
☐ Current Medication List/Regimen

B. OTHER PROVIDER INFORMATION

Agency Name: _____

Provider Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

MODES OF COMMUNICATION

(Check all modes of communication that you agree to)

☐ **All modes of communication listed**

☐ Phone ☐ Email ☐ Fax

☐ In person ☐ Mail ☐ Drop off/Courier

INFORMATION/DOCUMENTS THAT PROVIDER LISTED ABOVE CAN SHARE WITH BUILDING BRIDGES:

☐ Diagnostic Evaluation Report(s)
☐ Treatment Assessment Report(s)
☐ Treatment Recommendations
☐ Progress Report(s)
☐ Discharge Summary
☐ Other (specify): _____
_____
_____

☐ IFSP/IEP (most current)
☐ CMH Personal Plan
☐ Current Medication List/Regimen

OPT OUT

I do not wish, and do not give my permission to have information shared with:

☐ Other provider from above: _____
☐ I am not currently receiving services from any other service providers

CONSENT

I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the clinician/facility listed in Section B above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will remain in place for the duration of services or until the consumer states otherwise. I understand that I may revoke my consent at any time except to the extent that action has already been taken in reliance on it.

Parent/Guardian Signature: _____ Date: _____

FOR CLIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

NON-GUARDIAN AUTHORIZATIONS AT BUILDING BRIDGES THERAPY CENTER

Name of Child: _____

I hereby inform Building Bridges Therapy Center that the people listed below are authorized to pick up the above-named child at any time, receive private health information (PHI) feedback, and/or receive health documents. Accordingly, Building Bridges Therapy Center is hereby instructed to release my child, share PHI, or distribute health documents as indicated to the following people.

			Is authorized to (check all that apply):		
Name	**Relationship to Child**	**Phone Number**	*pick up child*	*receive PHI feedback*	*receive health documents*

I understand that:

- Parents/guardians must inform BBTC (call, leave a note at drop off) of the name of the person who is picking up their child on any day when they themselves are not.
- The "Authorized Pick-Up Person" must be at least 18 years old and may be asked to provide a photo ID to the staff.
- This authorization shall remain in force until edited or rescinded in writing by the signers of this authorization.

Authorized by:

_____ _____

Parent/Guardian Signature *Date*

_____ _____

Parent/Guardian Signature *Date*

Building Bridges
THERAPY CENTER

NOTICE OF PRIVACY PRACTICES

(Effective April 1, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN BELOW TO INDICATE YOU HAVE BEEN INFORMED OF THIS POLICY.

Understanding your treatment record - A record is made each time your child is treated at our clinic. This information is most often referred to as a "treatment file" and serves as a basis for planning and monitoring your child's care at our Clinic. It also serves as a means of communication among any and all staff involved in the care of your child.

Understanding your health and treatment information rights - Your child's treatment record is the physical property of the Clinic, but the content is about your child and, therefore, belongs to you. You have the right to request restrictions on certain uses and disclosures of your information and to request amendments to this record. Your rights include being able to review or obtain a paper copy of the information and to be given an account of all disclosures. You may also request that communication of this information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your treatment information.

Our responsibilities – This clinic is required to maintain the privacy of your treatment information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about your child. This Clinic is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations. This Clinic reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient treatment information. In the event that changes are made, this Clinic will notify you at the current address provided on your medical file. Other than for reasons described in this notice, this Clinic agrees not to disclose your treatment information without your authorization.

Your child's treatment information will be used for treatment, payment, and healthcare operations –

- *Treatment* – Information obtained by your therapist in this Clinic will be recorded in your child's treatment file and used to determine the course of treatment. This consists of your therapist recording his/her own expectations and those of others involved in providing care. The sharing of this information may progress to others involved in your child's care, such as physicians.
- *Payment* – Your healthcare information will be used in order to receive payment for services rendered by this Clinic. A bill may be sent to either you or a third party payer with accompanying documentation that identifies your child, a diagnosis, and procedures performed. Information may also be shared with any organizations that may be helping with the payment process.
- *Healthcare Operations* – The medical staff in this Clinic will use your child's health information to assess the care he/she received and the outcome of treatment compared to others like it. This information may be reviewed for quality improvement purposes in our effort to continually improve the quality and effectiveness of the care and services we provide.
- *Understanding our Clinic policy for specific disclosures* – It is our policy to not disclose any of your child's information without your specific authorization to do so. We may be required by law to disclose health information to public health authorities. Also, your health information may be disclosed for law enforcement purposes as required under state law or in response to a valid subpoena.

To receive additional information or report a problem – For further explanation of this notice you may speak with Stephanie or Brad Naberhaus. If you believe your privacy rights have been violated, you have the right to file a complaint with the Secretary of Health and Human Services.

NOTICE OF PRIVACY PRACTICES AVAILABILIITY: The terms described in this notice are posted in the waiting room. All clients will be given a hard copy and asked to acknowledge receipt.

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, and have copies available in our office.

NOTICE OF PRIVACY: I ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY PRACTICES.

_____ _____

Parent signature Date

Building Bridges
THERAPY CENTER

INFANT FEEDING 0-6 MONTHS
PERTINENT HISTORY QUESTIONNAIRE

Today's Date: _____

Name of infant:_____ Date of Birth:_____ Age:___
Address:_____
Street City State Zip Code
Ethnicity:_____ Language Spoken in Home:_____
Home Phone #:_____
Father's Name:_____ Cell Phone/Day Time #:_____
Occupation:_____
Mother's Name:_____ Cell Phone/Day Time #:_____
Occupation:_____

E-mail address:_____

Emergency Contact/Phone #:_____

Who referred you to Building Bridges Therapy Center?
_____

What is the relationship of the person completing this application to the infant?
Biological Parent: Mother_____ Father_____
Adoptive Parent: Mother_____ Father_____
Step-Parent: Mother_____ Father_____
Foster Parent: Mother_____ Father_____
Other: _____

Marital Status: ____Married ___Separated ____Divorced ____Other

All persons living in the home:
Name Age Relation to patient Highest Grade Completed
_____
_____
_____
_____

PARENTAL CONCERNS
Please describe the major concerns you have in seeking help for your infant.
_____

_____
_____
_____

How can this facility help you most with these concerns?

_____
_____
_____

MEDICAL HISTORY

Infant's Pediatrician or Family Doctor _____
Address_____
Street City State Zip Code

Please list any other doctors or clinics that have examined your infant:
Name Address Purpose of Examination

_____
_____
_____

Date of Last Medical Checkup:_____Height:_____Weight:_____

Has your infant been seen by a Lactation Consultant or breastfeeding specialist? Y/N
Are they currently under the care of: Y/N
Breastfeeding/Lactation Consultant Name and Address: _____

Does your infant have a diagnosis from treating physician:
Has your Infant had any medical tests done:

Does your infant take any medications on a regular basis? Yes_____ No_____
If yes, please list medication taken and amount:

_____
_____

Has the infant ever been hospitalized? Yes_____ No_____

	Hospital	Date	Reason
1.			
2.			

PREGNANCY

While pregnant did infant's mother have any of the following:

German Measles	Yes____ No____	*Emotional Problems*	Yes____ No____
Anemia (low iron)	Yes____ No____	*Vaginal Infection/Bleeding*	Yes____ No____
Diabetes	Yes____ No____	*High Blood Pressure*	Yes____ No____

High Fever	Yes____ No____	*Kidney problems*	Yes____ No____
Smoke cigarettes	Yes____ No____	*Drink alcohol*	Yes____ No____

Were any medications taken during pregnancy? (include vitamins and iron)

_____

_____

BIRTH

Was the infant born early? _____ Late?_____ or on time?_____
Was infant born by C-section? Yes_____ No_____
If yes, please give reason for C-section_____

Approximately how long was mother in labor?_____
What was baby's birth weight? _____ length?_____ Apgar Score?_____
What was baby's condition at birth?_____

ADOPTION
Describe the circumstances surrounding the adoption:

_____

_____

_____

FEEDING QUESTIONNAIRE

1. Please explain, in your own words, what your infant's current feeding problem is:

2. At what age did your infant's feeding problem first become a concern?_____

3. Are you breast or bottle feeding, or both? _____

Please describe your infant's initial experience on the breast and/or bottle:

4. Does your infant frequently arch, cry, spit up, gag, cough, vomit or pull off the nipple? (Circle the behaviors shown and describe when they would happen, and why, and for how long)

5. Describe how the weaning process off the breast and/or bottle went and why your infant was weaned:

At what age was your infant weaned off of bottle/breast?

How long did your infant receive breast milk?

6. At what age was your infant introduced to Baby cereal? _____
Please describe how these transitions were handled by your infant, especially if there were difficulties:

IF YOUR INFANT EATS BY MOUTH, PLEASE ANSWER THE FOLLOWING QUESTIONS:

7. Please circle how your infant eats the named texture:

Baby Cereal	easily	with difficulty	refuses	cannot eat	never tried
Baby food	easily	with difficulty	refuses	cannot eat	never tried
Puree table food	easily	with difficulty	refuses	cannot eat	never tried

8. Who typically feeds your infant?

How long is a Feeding?
How is infant positioned while eating? _____

9. How much liquid does your infant drink per day?

___0-8 oz	___8-16 oz	___16-24 oz	___24-32 oz	___32-40 oz

10. What times does your infant typically eat and what type?

Morning	Noon	Night
Breast | Bottle / Solids	Breast | Bottle | Solids	Breast | Bottle | Solids

11. Does your infant do any of the following during a mealtime?

refuse to eat	cries/screams	vomits	falls asleep	gag/coughs
spits out food				

IF YOUR INFANT IS *TUBE FED*, PLEASE ANSWER THE FOLLOWING QUESTIONS:

12a. Type of tube used: (circle one) NG, G, G-J

12b. What type of formula is used and exactly how do you mix it?

12c. What is name and specialty of provider who tells you what to give through the tube?

12d. Describe what environment your infant is tube fed in and what activities are occurring at the same time:

12e. Describe your infants reactions/affect to the tube feedings (connecting, during, disconnecting):

12f. Please detail your infant's feeding schedule below(please include times and amount given).

PLEASE ANSWER FOR ALL

13. How do you know your infant is hungry or full?
    Hungry?

    Full?

14. Has your infant lost any weight?

15. Would you describe your infant's weight as (circle one): Ideal Underweight Overweight

16. Does your infant have/had any of the following problems (circle which ones)? Please describe:
frequent constipation, frequent diarrhea, vomiting, choking, gagging, coughing

17. Does your infant take a vitamin supplement? Which one?

18. Describe how you, and your infant feel after a feeding:

You:

Your infant:

19. What other evaluations have been completed regarding your infant's feeding difficulties and what were the results/what were you told?

20. What treatments have been tried for this problem, and what were the results?

21. Does your infant have any physical pain while (associated with)feeding? __yes __no

None		Mild			Moderate					Severe
0	1	2	3	4	5	6	7	8	9	10

22. How often does your infant have a bowel movement? __daily __every other day __other

23. Does s/he have issues with : Constipation(hard stools) __yes __no
Diarrhea (loose stools) __yes __no