Picky Eaters Group Registration Form

Our Picky Eaters Group starts September 11 and runs weekly on Wednesdays until November 13. The group meets from 2:30pm - 3:45pm. The age range is 3-6 years old. Maximum group size is 6. Using the SOS Feeding Approach, this group will work on developing a positive and healthy relationship with food, learn mealtime routine and cues to eating, decrease resistance to touching, tasting and swallowing food, increase the range of foods the child will try, and increase the volume of food ingested. The program cost is $600. A $100 non-refundable deposit is required to secure a place. The balance must be paid by September 1st. This is a 10 week program and to receive the full benefits of the program, participants need to attend each week.

An introductory parent presentation will be held on Monday, September 9.

Prerequisites:

- Can separate from caregiver
- Can participate in group activities
- Can attend to a seated task for 20 minutes

Please indicate what you would like to pay. You may pay by check, cash or credit card. Credit card payments can be taken over the phone.

☐ Deposit ☐ Full balance

Please make checks payable to Solaris Pediatric Therapy. Write the name of your child on the check. Checks may be mailed to PO Box 66701, Houston, TX 77266 or left with our office manager, Allyson Alli. Payments are non refundable.

Return this form to office@solarispediatrictherapy.com or mail to our PO Box.

REGISTRATION INFORMATION:

Today's date:	

Child's name:		DOB:	
Height:		Weight:	

Parent/Guardian Name:			
Email:		Phone:	
What is your major concern regarding your child's feeding:			
Allergies:			
Has your child been diagnosed with a medical condition? Please specify.			
Please describe your child's feeding schedule:			

Please check the box that describes your child's current intake of the following food types:						
Consistency	***Does Eat***	***Can Eat***	***Can't Eat***	***Won't Eat***	***Never Tried***	***Comments***
Regular liquid						
Thick liquid						
Purees						
Mashed table food						
Chopped table food (easy to chew, small pieces)						
Regular table food						

Crisp food (crackers)						
Chewy food (meat)						
Crunchy food (carrot)						

Please list various foods, flavors, textures that are favorites/easy or dislikes/difficult	
Favorite/Preferred/Easy	*Dislikes/Refuses/Difficult*
How does your child let you know that they're hungry?	
Who usually feeds your child?	
Which other individuals feed your child? E.g. aunt, nanny	

Where is the child usually fed?							
Lap		Table/chair		High chair		Stand/roam	
Infant seat		Floor		Couch		Other:	
Describe the environment/location:							
How long do meals typically last?							
How much food is your child able to finish in a typical meal?							

Please check behaviours which concern you. Please indicate with an exclamation mark (!) those most concerning to you.							
Eats too fast		Eats non-food items		Vomits		Pushes food away	

Eats too much		Uses a bottle		Drools		Fails to suck	
Refuses to open mouth		Reflux		Messy eater		Throws or drops food	
Spits food out		Eats too little		Leaves table		Cries or tantrums	
Turns away from food		Fails to chew food		Ruminates		Plays with food	
Refuses to swallow food		Gags		Eats to slow		Picky eater	
Sneaks or steals food		Other:					

Please check any techniques that you have used to get your child to eat. Please indicate with an exclamation mark (!) the techniques that are the most effective.							
Threaten		Forced feeding		Model		Limit foods	
Coax		Praise		Spank		Offer small meals	
Offer reward		Use TV/Video		Change food offered		Ignore	
Send to time-out		Change meal schedule		Distract with play/toys			
Other:							

What are your goals for your child?					
Increased weight gain		Increase the textures of food		Decrease gagging during eating	
Increase amount of food		Increase variety of foods		Improve mealtime behaviours	
Other:					

Additional Comments:

Please list any additional information you feel is important for the therapist to know.

Medical Release

In the event that we cannot be reached to make arrangements for Emergency Medical Attention for our child/children, we hereby authorize representatives of Solaris Pediatric Therapy to give consent for any and all necessary emergency medical care. In consideration of this necessary emergency medical care, I agree to hold Solaris Pediatric Therapy, its employees, members, and volunteers free from any liability for any injuries my child may sustain while being treated in accordance with said medical release. If required, I instruct Solaris Pediatric Therapy to inform emergency medical staff to transport my child/children to the nearest hospital or urgent care center. In the absence of a preference, your child will be taken to the nearest hospital or minor emergency clinic.

Hospital/urgent care preference:	

Parent / Legal Guardian Signature Date

Child's PCP:		Phone number:	

Media Release

I agree to allow Solaris Pediatric Therapy to photograph/ video my child/children for educational and promotional purposes. I understand that these photos/ videos may be used for public viewing. I understand that my consent may be withdrawn in writing at any time.

Parent / Legal Guardian Signature Date

If your child is not a previous or current client, please indicate how you heard about us:

Questions? office@solarispediatrictherapy.com 832-727-3771