Intake Form for Feeding Evaluation

Child's Name: ________________________ Date of Birth: ____________________________

Parent/Caregiver: ____________________ Parent/Caregiver:________________________

Address: ____________________________ City, State, Zip:___________________________

Home Phone or cell: ____________________ Cell: ______________________________________

Email Address: ____

Primary caregiver during the day: ____
Daycare, preschool/ school, other caregivers: ____
Siblings (name & age): ____

Who referred you or how did you find us? ____

Feeding Issues: What is/are your feeding concern(s)? ____________________________________
____
____
____

Please share how your child's feeding difficulties negatively impact his/her life and the daily routines of the family (i.e., worry about choking, weight gain, stressful mealtimes, negative impact on siblings, etc.) ____
____
____

What are your feeding goals for your child? ____
____
____

Medical Team

Primary Care Physician/Pediatrician: ____

Gastroenterologist: ______________________________ ENT: ______________________________

Allergist:_____________________________ Dentist: ______________________________________

Other Specialists:____

Is your child in Early Intervention or receiving other therapy? Y/N Speech OT PT
Name: _______________________ Location: ________________________Frequency:_____________

Medical Information
Medical Diagnoses: ____
Overall Development: Normal/Delayed. If delayed, what areas? _________________________
____

Pregnancy (circle): Full term Premature **Delivery**: Vaginal C-Section

Assisted Birth: N/Y- Forceps/Vacuum Complications during pregnancy or during/following delivery: No/Yes ____
Was respiratory/nutritional support needed following delivery? No/Yes ___________________

Feeding tube? No Yes (If yes, please complete additional Tube Feeding Intake Form)

Health history: Hospitalizations/ Illnesses (month/year & reason): ____________________
____
Ear Infections Y/N? how many? _______ ear tubes Y/N if yes, are they still in place? Y/N
Eczema? where on body? ___________________________ is medication/treatment given for eczema? ______________________ irritability upper resp. infections asthma seizures pneumonia rash hives strep throat reflux/GERD GI issues/ discomfort
Other____
Current Weight: ________ **%ile** Current Length/Height: _______ **%ile**
Is/ has weight gain and/or growth been a concern? Yes No

Medications (prescription and over the counter): _______________________________________
____
Vitamin supplement? N/Y Please list kind: __________________ Frequency: ______________

Testing
Swallow Study (MBSS) Date: ____________ Results: ________________________
Endoscopy Date: ____________ Results: ________________________
Gastric Emptying Date: ____________ Results: ________________________
pH probe Date: ____________ Results: ________________________
Upper GI Date: ____________ Results: ________________________
Allergy Testing: Skin Test Date: ____________ Results: ________________________
Blood Test Date: ____________ Results: ________________________
Describe any special diet or food intolerance: ____

Bowel Habits: Constipation? Yes No If yes, do you use any treatments? _______________
Frequency of bowel movements _________ times per day/ week (circle one)
Consistency of stools:___________________________ Visible mucous or blood ? Yes No

Sleep Habits: Does your child sleep well? Yes No hours per night? ____________
Take nap(s)? Yes No Does your child sleep with an open or closed mouth? ______________
Does your child snore? Yes No Is your child a restless sleeper? Yes No
Does he/she wake during the night? Yes No If yes, how does he/she go back to sleep?
____

Feeding History
Breastfeeding? Yes No How many months? _______________________
Any difficulties with nursing? ____
Did you see a lactation consultant? ____
Bottle fed : Yes No breast milk formula or both? __________________________________

Please list previous and current formulas & describe tolerance: ______________________________
____
____
Solids: at what age where baby cereals and purees introduced? ______________________________
Any problems? ____

Please circle the stages of baby food that your child ate/eats: 1st/2nd/3rd/homemade purees/soft solids/table foods Any problems? _______________________________________
____
Does/did your child accept a variety of purees or was he/she picky during infancy? __________
____
Has your child had feeding difficulties since infancy, has there been a gradual decline over time, or was there an "incident" or specific point in time when eating patterns changed? Please explain: ____
____
____

Current Meal Pattern

Does your child eat better or worse at any particular mealtime? ______________________________
Do you know why one meal is better than another?____________________________________
How long does a 'typical' meal take? ___________________________________
Is the biggest concern the lack of variety or volume or both? ________________________________
Are there particular textures and/or colors of foods that are refused? _________________________
Child's current diet:
Meats/proteins: ____
Fruits: ____
Vegetables:____
Carbs:____
____
Dairy:____
Desserts/Sweets/Snacks:____
Other:____
Please list non-preferred or refused foods: ____
____
Are there foods that your child used to eat but now refuses? ________________________________
____

Liquids: Formula: _________________________ ____________oz./day circle: cup bottle
Milk: type ___________________%, _________oz./day cup bottle
Water ________oz./day juice ________oz./ day cup bottle
other drinks: _____________________oz./day cup bottle

Your child's typical meal schedule   Number of meals/snacks: ________________________
Time of meals and snacks:____
My child grazes throughout the day   Yes   No

What does your child drink from (circle): Bottle   Sippy Cup   Open Cup   Straw
Is your child able to self-feed? Y/N with utensils? Y/N

Feeding Practices

Who feeds your child? ____
Does your child eat better for a particular feeder? N/Y   Who? ________________________________

Do you sit for family meals on a regular basis? ____

Where does your child currently eat (circle all that apply)?
Table/Chair Highchair Adult's Lap Infant seat Sofa Crib/Bed Car seat
Modified Chair Booster Roaming- Kitchen/other rooms in the house
Other: ____

Feeding techniques you use with your child to get him/her to eat? Circle all that apply.
Coax Praise Change meal schedule Threaten Ignore Punish Force feed
Distract with TV/toys Offer reward Offer favorite foods Send to room/timeout
Offer mini-meals Allow grazing/roaming Chase around house with food
Other: ____

What do you do if your child refuses to eat/drink? ____
____

Feeding Behavior

Does your child experience any of the following?

Choking	Yes/No	what types of food? ______________________
Aspiration	Yes/No	what types of food? ______________________
Gagging	Yes/No	what types of food? ______________________
Hypersensitive	Yes/No	what types of food? ______________________
Coughing	Yes/No	what types of food? ______________________
Vomiting	Yes/No	what types of food? ______________________
Problem with biting	Yes/No	what types of food? ______________________
Difficulty Chewing	Yes/No	what types of food? ______________________
Overstuffs mouth	Yes/No	what types of food? ______________________
Pocket food	Yes/No	what types of food? ______________________
Drooling	Yes/No	Teeth Grinding: Yes/No
Sweating	Yes/No	Excessive burping hiccups gas bloat?

Does your child exhibit any of these behaviors at mealtimes? Circle all that apply.
Cries or screams Refuses to self-feed Spits food out Throws food Pocket Food
Eats to fast/slow Refuse to swallow Push food/spoon away Does not suck
Leave table Induces Vomiting Clenches lips shut Other: ___________________________

How does your child indicate hunger? ____

Is there something we forgot to ask, that you think would be helpful for us to know?
____

Do you have any concerns about your child's communication development or skills? Yes No

We look forward to meeting you and your child!