



## 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? No Speech OT PT

Location: \_\_\_\_\_

**Medical Information**

Medical Diagnoses: \_\_\_\_\_

Overall Development: Typical Delayed If delayed, what areas? \_\_\_\_\_

**Pregnancy:** Full term Premature Complications? \_\_\_\_\_

**Delivery:** Vaginal C-Section

Assisted Birth: Forceps/Vacuum used? Any complications during or following delivery? \_\_\_\_\_

Was your child in the NICU? If so, how long \_\_\_\_\_

Was respiratory or feeding support needed after delivery? \_\_\_\_\_

**Health history:** Hospitalizations/ Illnesses (month/year & reason): \_\_\_\_\_

Ear Infections: how many? \_\_\_\_\_ ear tubes Yes No Are they still in place? Yes No  
Eczema Where on body? \_\_\_\_\_

Is medication/treatment used for eczema? Yes No \_\_\_\_\_

Irritability Upper respiratory infections Asthma Seizures Pneumonia Rashes

Hives Strep throat Reflux/GERD Tongue tie GI issues/ discomf

Other medical concerns: \_\_\_\_\_

Current Weight: \_\_\_\_\_ %ile Current Length/Height: \_\_\_\_\_ %ile

Has weight gain and/or growth been a concern? Yes No

**Medications** (prescription and over the counter): \_\_\_\_\_

Vitamin supplement? Yes No Name/brand: \_\_\_\_\_ Frequency given: \_\_\_\_\_

**Testing**

Swallow Study (MBSS) Date: \_\_\_\_\_ Results: \_\_\_\_\_

Endoscopy Date: \_\_\_\_\_ Results: \_\_\_\_\_

Gastric Emptying Date: \_\_\_\_\_ Results: \_\_\_\_\_

pH probe Date: \_\_\_\_\_ Results: \_\_\_\_\_

Upper GI Date: \_\_\_\_\_ Results: \_\_\_\_\_

Allergy testing: Foods Environmental 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

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 your child use a pacifier? Yes No Suck his/her thumb/fingers? 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? Yes No Did you see a lactation consultant? Yes No

Bottle fed: Yes No When was the bottle introduced? \_\_\_\_\_

What is given in the bottle? breast milk formula both other \_\_\_\_\_

Please list previous and current formulas & describe tolerance: \_\_\_\_\_

Solids: What age were baby cereals and purees introduced? \_\_\_\_\_

Any problems? Explain: \_\_\_\_\_

Stages of baby food that your child ate/eats: homemade purees store bought purees  
lumpy, textured purees stage 3 baby foods dissolvables soft solids regular table  
foods Any problems? Yes No Explain any difficulties \_\_\_\_\_

Does/did your child accept a **variety** of purees and/or solids during infancy? Yes No

My child has had feeding difficulties since:

infancy

there been a gradual decline over time -when did the decline start? \_\_\_\_\_

there was an "incident"(i.e. choking, illness, etc.) 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 volume both

Are particular textures, types or colors of foods 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? \_\_\_\_\_

<b>Liquids:</b> Formula: _____ oz./day	open cup	straw	bottle
Milk: type _____%, _____ oz./day	open cup	straw	bottle
Water _____ oz./day	open cup	straw	bottle
Juice _____ oz./ day	open cup	straw	bottle
Other drinks: _____ oz./day	open cup	straw	bottle

Does your child eat meals and snacks on a schedule? Yes No

Does your child graze throughout the day? Yes No

Time of meals and snacks: \_\_\_\_\_

Do you sit for family meals on a regular basis? \_\_\_\_\_

### **Feeding Practices**

Who feeds your child? \_\_\_\_\_

Is your child able to self-feed? Yes No With utensils? Yes No

Where does your child currently eat?

Table/Chair Highchair/Booster seat    Adult's Lap    Infant seat    Sofa    Crib/Bed  
Car seat    Modified Chair    Roaming- Kitchen/other rooms in the house

Other: \_\_\_\_\_

Feeding techniques you use to get him/her to eat?

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	what types of food?	_____
Aspiration	what types of food?	_____
Gagging	what types of food?	_____
Hypersensitive	what types of food?	_____
Coughing	what types of food?	_____
Vomiting	what types of food?	_____
Problem with biting	what types of food?	_____
Difficulty Chewing	what types of food?	_____
Overstuffs mouth	what types of food?	_____
Pocket food	what types of food?	_____

  Drooling    Sweating    Excessive burping    Hiccups    Gas/Bloat    Teeth grinding

Does your child exhibit any of these behaviors at mealtimes?

  Cries/screams    Refuses to self-feed    Spits food out    Throws food    Eats too  
fast/slow    Refuse to swallow    Push food/spoon away    Leaves the 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?    Yes    No

We look forward to meeting you and your child!

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