Huntington Speech & Feeding
215 East Main Street, Suite 206
Huntington, NY 11743
(631) 606-3439

FEEDING HISTORY INTAKE FORM

Child's Name: _____ Date of Birth: _____Age_____

Pediatrician: _____ Phone Number of Pediatrician _____

Reason for Referral:

_____

Parent's Name (s): _____ Home Phone: _____

Cell Phone: _____ Email: _____

Home Address: _____

Parent's Occupation: _____

Child's School: _____ Grade: _____

Child lives with (check one):
□ Birth Parents □ Foster Parents □ Adoptive Parents □ One Parent □ Other:

Family History:

Siblings and ages: _____

Is there a family history of speech or feeding issues: □ Yes □No

Did/does your child receive any services? (OT, Speech, PT, Special Ed) □ Yes □ No

When did your child speak first words? _____ speak in sentences_____ stand _____

walk _____

Does your child exhibit anxiety in new situations or anxiety around food? (If yes please explain)

_____

_____

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PERTINENT PAST AND CURRENT MEDICAL HISTORY

Length of pregnancy (weeks) _____

Any complications with pregnancy or delivery? □ Yes □ No

If yes, please explain: _____
_____

Birth Weight: _____ Twin □ Yes □ No

Hospitalizations/Surgical History

Date(s): _____

Reason for Hospitalization:
_____
_____

Date(s): _____

Reason for Hospitalization:
_____
_____

Known Precautions/Allergies (please check)
Medical allergies: □ Latex □ Other _____
Food Allergies: □ Dairy □ Gluten □ Soy □ Nuts □ Other Epipen □ Yes □ No

Current Medications: (Please List)

_____ For: _____

_____ For: _____

_____ For: _____

Additional Medications: _____

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Neurological History/Current Concerns

HISTORY or CURRENT neurological deficits □ Yes □ No

Please explain: (low muscle tone, seizures etc.)

_____

_____

Neurologist's Name and phone number if applicable:

_____

Cardiac History/Current Concerns □ Not Applicable
HISTORY of heart problems □ Yes □ No

Does your child have **CURRENT** cardiac issues/needs? □ Yes □ No

Name of Current Cardiologist and phone: _____

Respiratory History/Current Respiratory Concerns □ Not Applicable
History of respiratory problems (check all that apply if applicable)

□ Apnea □ Asthma □ Pneumonia □ Bronchitis □ Nasal/Chest Congestion
□ Malacia bronch □ Malacia laryngo □ Malacia trachea □ BPD □ Wheezing

Any breathing treatments? _____

Have your child's tonsils or adenoids been removed? □ Yes □ No

Please specify surgery date and if one or both were removed or shaved:

_____

How many colds each year? _____

How many upper respiratory infections? _____

Does your child have **CURRENT** issues/needs for respiratory problems □ Yes □ No

Current ENT doctor name and phone: _____

Current Pulmonary doctor and name: _____

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Gastrointestinal History/Current GI Concerns □ Not Applicable

HISTORY of GI deficits □ Yes □ No

If yes, please check all that apply

□ Altered Peristalsis □ Bowel Obstruction □ Crohn's Disease □ Chronic Diarrhea
□ Constipation □ Dehydration □ Diabetes □ Esophagitis (Eosinophilic)
□ Failure to Thrive □ Slow Gastric Emptying □ Short Bowel □ Vomiting

HISTORY of GI surgeries? □ Yes □ No

Did your child receive any alternative feeds? □ Yes □ No
If yes **please circle** (G tube, J tube, NG tube, PEG tube)

Has your child had any of the following tests completed? **Please circle** (MBS, FEES study, Upper GI, Ph Probe), Other

_____

CURRENT GI status: □ No problems □ Current Issue □ Regular follow up with Gastroenterologist (Name and phone)

_____

Do you or your doctor have any concerns about recent weight gain or loss? □ Yes □ No
If yes, please explain

_____

Has your child had a nutritional consult? □ Yes □ No

If yes, please state nutritionists name and phone:

_____

Craniofacial Concerns
HISTORY of lip or palate defects? □ Yes □ No

Sinus Infections? □ Yes □ No Diagnosed Genetic Syndrome? □ Yes □ No

Do you ever notice food coming out of the nose? □ Yes □ No

Dental Concerns □ Yes □ No

Please circle (Narrow Palate, High Palate, Crowding of Teeth, Tongue Tie, Lip Tie)

Hearing History/ Current Hearing Concerns □ Yes □ No
Please list: _____

How many ear infections has your child had? _____

Does your child have ear tubes placement? □ Yes □ No

Has your child had chronic ear infections? □ Yes □ No

ORAL MOTOR AND FEEDING HISTORY

Please explain your concerns regarding your child's feeding/eating difficulties (intake, biting, swallowing, chewing):

_____

_____

Was/Is your child bottle fed or breast fed? If so, for how many months/years? _____

How many ounces of formula or breast milk daily?_____

What type of nipple do you use? _____

If on formula please list brand _____

How many formulas did your child try to find the right one? _____

If your child is not using a bottle, when did they transition to a cup? _____

How many ounces does your child drink via cup? _____

Where does your child eat? _____

What kinds of food does your child eat regularly? Check all that apply.

□ Breast milk _____ □ Formula _____ □ Thin liquids _____ □ Thickened liquids ____

□ Pureed food ____ □ Mashed table food _____ □ Chopped table food ____

□ Regular table food _____ □ Other _____

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Variety of foods: Check all that apply.

□ Fruit □Vegetables □Grains □ Dairy □ Meat

If your child is eating solids, at what age was solid food introduced? _____

Does he/she feed him/herself? □ Yes □ No

Does he/she use utensils? □ Yes □ No

Does your child take any nutritional supplements? If yes, please indicate product, amount & frequency. _____

How do you if your child is hungry? _____

How do you know you're your child is full? _____

Is your child having trouble losing weight? _____

Is your child having trouble gaining weight? _____

Does your child use a pacifier? □ Yes □ No

What type of cup does your child drink from? _____

Does your child dislike being touched around his/her mouth? □ Yes □ No

How does your child respond to tooth brushing? _____

Does your child drool? If yes, please indicate often, infrequent or occasionally _____

Does your child choke on liquids or solid foods? □ Yes □ No

Does your child stuff his/her mouth? □ Yes □ No

Do you see your child gagging? □ Yes □ No

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Does your child have food **preferences/aversions**? □Yes □No
If yes, please explain:

_____

_____

Accepted foods:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Sometimes Foods or Foods that your child used to eat and lost

_____

_____

_____

_____

Rejected Foods:

_____

_____

_____

_____

_____

Is any adaptive equipment being used during feedings? □ Yes □ No. If yes, please elaborate.

_____

What seems to help (or not help) your child during mealtime?_____

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Please check off any behaviors that apply to your child *during meals*:

- ☐ Choking
- ☐ Food or liquid coming out of nose
- ☐ Eats too much
- ☐ Eats too little
- ☐ Difficulty swallowing
- ☐ Trouble breathing
- ☐ Fussy, cranky
- ☐ Spitting out food
- ☐ Pushing food out
- ☐ Delayed swallow
- ☐ Gagging

- ☐ Holding food in mouth
- ☐ Crying
- ☐ Pocketing food in mouth
- ☐ Noisy breathing
- ☐ Wet quality to voice
- ☐ Gagging
- ☐ Reflux
- ☐ Vomiting
- ☐ Falling asleep
- ☐ Refusal to eat
- ☐ Head turning
- ☐ Mouth closing
- ☐ Stiffening
- ☐ Hyperextension
- ☐ Other behaviors

_____

Does your child demonstrate negative behaviors during mealtime? Please check all that apply.

- ☐ Throws food
- ☐ Spits food out
- ☐ Leaves table before done
- ☐ Messy eater
- ☐ Trouble with self-feeding
- ☐ Trouble with chewing
- ☐ Trouble with swallowing
- ☐ Refusal to eat
- ☐ Takes food from other's plate
- ☐ Other

_____

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SCHEDULE OF MEALS/SNACKS (please indicate time your child consumes breakfast, lunch, dinner and snacks below.