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FEEDING HISTORY INTAKE FORM

Child's Name: ___________________________Date of Birth: ___________________Age______

Referring Physician: __________________Phone Number of Physician: ____________________

Reason for Referral/Concerns:

____

____

What are your goals?

____

Parent's Name (s): ____________________________ Home Phone:_________________________

Cell Phone: __________________________________ Work Phone: ________________________

Home Address: ____

Email: ____

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

Sat up at _________ Crawled at _______ Walked at _______ First words _______

Spoke in Sentences ______Toilet Trained ______Used Utensils ______ Drank from cup _____

Where does your child go to school and days/hours?

____

Does your child currently receive any therapy services (OT, PT, Special Ed, ST)? ◻ Yes ◻ No

If yes, please list

____

Has he/she had feeding services in the past? □ Yes □ No

If yes, please list

____

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

Reason for Hospitalization:

____

____

Date(s): ____

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: ____

NEUROLOGICAL HISTORY/Current Concerns •Not Applicable

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 □ Yes □ No

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: ____

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 consultation? □ Yes □ No
If yes, please state nutritionists name and phone: _______________________________________

CRANIOFACIAL CONCERNS • Not Applicable
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, crossbite)

HEARING HISTORY/ Current Hearing Concerns? □ Yes □ No
When was your child's last hearing exam and what were the results?

____

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, sensory issues):

____

____

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 (high chair, standing, by TV, with Ipad, in bed?

____

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 _____

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 know when your child is hungry? ____

How do you know when your child is full? ____

Is your child having trouble losing weight? ____

Is your child having trouble gaining weight? ____

Does your child use a pacifier? ____

What type of cup does your child drink from? ____

Does your child dislike being touched around his/her mouth? _______________________________

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? ____

Does your child stuff his/her mouth? ____

Do you see your child gagging? ____

PLEASE INCLUDE DAILY MEAL AND SNACK SCHEDULE BELOW: (include time)

____

____

____

____

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? _________________________________

What seems to help (or not help) your child during mealtimes? What techniques do you use to increase intake?____

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 ____

Does your child demonstrate behavior difficulties around daily routines (e.g. getting ready for school, bathtime, bedtime)? Please explain

____

____

____

____

Does your child demonstrate any anxiety around peers, adults, birthday parties, new situations? Please explain

____

____

____

Does your child have any sensory issues (e.g. touching consistencies, tags on clothing, loud noises, gagging when smelling food)? Please explain

____

____

____

Thank you for filling out this comprehensive form for this assessment :)