

Feeding Therapy Intake

Date Completed: ____/____/____

Please bring the items below to your appointment. Thanks!

- 1) A beverage
- 2) Three preferred foods
- 3) Three "goal" foods (age-appropriate items your child is not currently eating that you would like him/her to eat)
- 4) Any specialized feeding equipment (utensils, cup, etc.)
- 5) Communication device (or visual supports) if applicable

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____/____/____ Sex: Male Female Nickname: _____

Primary Language: _____ Secondary Language: _____

Referral Information

What is it specifically that you would like for us to look at? What would you like to get out of the evaluation?

Has the patient has participated in outpatient feeding therapy in the past? Yes No

If yes, were they discharged from therapy? Yes No

Please explain:

What are your primary concerns? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Not eating enough variety/
selective eater | <input type="checkbox"/> Eating too fast/overstuffing | <input type="checkbox"/> Won't stay at table |
| <input type="checkbox"/> Not eating enough volume | <input type="checkbox"/> Refuses to eat | <input type="checkbox"/> Poor growth |
| <input type="checkbox"/> Difficulty transitioning from
tube to oral feeding | <input type="checkbox"/> Only eats crunchy solids | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Holds food in mouth/pocketing
in cheeks | <input type="checkbox"/> Excessive saliva or drool |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Only eats purees | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Spitting food out | <input type="checkbox"/> Messy eater/food spillage from
mouth | <input type="checkbox"/> Tooth brushing intolerance |
| <input type="checkbox"/> Coughing after
eating/drinking | <input type="checkbox"/> Other: | |

Feeding History

Was your child breast fed? Yes No

If yes, how long? _____

Were there any problems with breast feeding (poor suck, slow to feed)? Yes No

If yes, please explain. _____

When did your child transition to bottle? _____

Were there any problems with bottle feeding? Yes No

If yes, please explain. _____

When did your child start to eat baby food/puree solids? _____

When did your child start to eat table foods? _____

When did your child start to self-feed? _____

Clinical Information

What is your child's weight? _____ height? _____

Does your child have any food allergies or specialized diet? Yes No

If yes, please explain: _____

How many times a day does your child eat? _____

Does he/she feed himself? Yes No

If yes, finger feeding or utensils? _____

What consistency of foods does your child eat?

regular liquids thickened liquids purees lumpy/chunky crunchy chewy

Does your child avoid any consistencies or textures? Yes No

If yes, please explain. _____

How is liquid presented?

breast bottle sippy cup cup with straw open cup

Approximately how much food does your child eat at each meal?

Approximately how much liquid does your child drink at each meal? _____

How long does each meal take? _____

What do you do when your child does not eat?

What are your child's favorite foods?

What foods will your child NOT eat?

What foods would you like your child to eat?

Mealtime Environment

What are the family's eating routines (i.e. eat meals together, same time every day)?

Where does your child usually sit at mealtimes?

- High chair Chair (with/without arms) Standing at/near table In front of the TV
 Caregiver's lap Booster seat Eats on the move

Where in the house does the child eat? _____

Is it the same for every meal? Yes No

Does your child do any of the following during mealtime?

- Throws food Throws utensils/food Spits food out Cries/screams Tries to get out of seat

What is the mealtime environment like?

- Quiet Busy/lots of people around Dimly lit
 TV on in the background Cluttered/lots of things on table Bright lighting

Gastrointestinal

How often does your child have a bowel movement? _____

Does your child experience any of the following? Diarrhea Constipation Vomiting None of these

If yes, please explain: _____

Has he/she been treated for growth problems? Yes No

Does your child receive supplemental (tube) feeding? Yes No

If yes: Amount _____ Rate _____