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)

☐ Not eating enough variety/ selective eater
☐ Eating too fast/overstuffing
☐ Won’t stay at table
☐ Not eating enough volume
☐ Refuses to eat
☐ Poor growth
☐ Difficulty transitioning from tube to oral feeding
☐ Only eats crunchy solids
☐ Constipation
☐ Gagging
☐ Holds food in mouth/pocketing in cheeks
☐ Excessive saliva or drool
☐ Vomiting
☐ Only eats purees
☐ Diarrhea
☐ Spitting food out
☐ Messy eater/food spillage from mouth
☐ Tooth brushing intolerance
☐ Coughing after eating/drinking
☐ 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 __________________