Mass General Brigham
Spaulding Rehabilitation

Date Completed: _____/_____/_____
Patient Name: _____
Date of Birth: _____/_____/_____

Feeding and Swallowing Intake

Background/Medical Information:

Growth:

Birth Weight: _____lbs. _____oz. Current or last weight: _____ lbs. _____oz. (date):_____
Birth Length: _____in. Current or last height: _____ ft. _____ in. (date): _____
Placement on growth curve: □ Remaining steady □ Lower/falling □ Increasing
Do you have concerns with your child's growth? □ Yes □ No
Has your child been treated for growth problems? □ Yes □ No
Please explain: _____
Has your child had any procedures or medical studies related to swallowing?
Please provide study and date: _____

Has your child experienced difficulty with any of the following? (Check all that apply)

Prolonged/high fevers		Ear infections		Cardiac issues		Tongue tie	
Elevated lead levels		Tonsils/ Adenoids		Respiratory issues		Lip tie	
Skin rashes/eczema		Hearing		Vision		Dental issues	

Please explain: _____
_____

Gastrointestinal:

Does your child have or has your child ever had reflux? □ Yes □ No
If yes please explain (age of onset, symptoms, if resolved, medications taken, imaging studies):
_____
_____
Did your child have a Nissen Fundoplication? □ Yes □ No If yes, date: _____
How often does your child have a bowel movement? _____
Does your child experience constipation or diarrhea? □ Yes □ No
If yes, please explain_____

Sensory:

Check below if you child does NOT tolerate the following:

Being messy in play		Having food on hands or face		Loud noises		Certain clothes/tags	
Bright lights		Brushing teeth		Baths/Showers		Other:	

Please describe_____

Check below if any of the following apply to your child:

Unaware when face is messy		Mouth non-food items	
Seek movement		Struggle to sit for meals	

Please describe_____
Does your child have difficulty falling asleep? □ Yes □ No
Does your child have difficulty staying asleep? □ Yes □ No
If yes, please explain: _____
_____

Feeding/Swallowing History:

Was your child bottle or breast fed as a baby? If breast fed, at what age did you wean the baby?
_____
Did your child have any challenges with early breast or bottle feeding? □ Yes □ No
If yes, please explain: _____
Did your child require formula changes: □ Yes □ No

At what age did you first introduce solid foods? _____

Texture	Age Introduced	Type of Foods	Difficulties/Notes
Stage 1 baby food (purees)/infant cereals			
Stage 2 baby food (strained foods/ thick purees such as oatmeal)			
Stage 3 baby foods (pureed with chunks)/mashed/ chopped			
Table foods			

How did your child tolerate the transitions to new foods?

_____

_____

Has your child shown regression in their feeding? □ Yes □ No

If yes, when did this occur? _____

Were there any contributing factors to the regression (e.g., illnesses, family changes or moves, accidents)? _____

_____

Has your child ever received supplemental or primary Tube feeding? □ Yes □ No

Type (NG, G, G-J, J, TPN): _____ When was the tube placed?_____

For what reason? _____

Please describe current administration parameters (# feeds/day, frequency, length, Bolus/gravity, formula):

_____

_____

Does your child finger feed? □ Yes □ No

Does you child drink from the following? (Check all that apply)

Bottle		Sippy cup		360 cup		Open cup		Straw	

Is your child able to use the following utensils? (Check all that apply)

Spoon		Fork		Knife	

Where does your child usually sit at mealtimes?

Highchair		Chair with/ without arms		Standing at/near table		In front of the TV	
Booster seat		Eats on the move		Caregiver's lap		In the car	

Who typically feeds your child?

Self -feeds		Mother		Father		Sibling	
Grandparent		Daycare provider		Teacher		Other:	

How long does a meal take?_____

How many meals/snacks is your child offered during the day? _____ At night? _____

Where and with whom does your child eat the best?

_____

Are the people who commonly feed/eat with your child implementing everything the same way? □ Yes □ No

Does your child require distractions to eat? (Please explain): _____

_____

How would you describe your child's interest in food/appetite?

Good		Fair		Poor		Varies	

Please describe: _____

_____

Does your child eat a good volume of preferred foods? □ Yes □ No

How does your child communicate hunger or thirst: _____

When eating, does your child: (Check all that apply)

Spit out food		Gag on food		Cough while eating		Cough after eating	
Throw food/utensils		Stuff food in their mouths		Hold food in their mouth/ cheeks		Eat a limited amount of food	
Cry or scream		Refuse food		Vomit		Try to leave seat or table	

Is mealtime stressful?

Never		Sometimes		Most of the time		Always	

What do you do when your child does not eat appropriately? _____
What have you done to try to help your child with his/her feeding problem?

_____

_____

Does your family follow a specific diet? (If so, please explain):_____

_____

What foods/types of foods does your child eat on a regular basis?

Fruits	*Vegetables*	*Dairy(milk, cheeses, yogurt, ice cream)*	*Proteins (Meats/poultry/fish/eggs/beans/nuts*	*Carbohydrates Breads/grains/cereals/crackers, cookies/rice/pasta/snack foods*	*Drinks/Liquids/ Formula*

Are there specific textures, flavors, or temperatures your child avoids? □ Yes □ No
Please list _____
If applicable, please list any previously eaten foods that are no longer tolerated due to increasingly selective eating:

_____

_____

Please share any additional information you would like for us to know about your child:

_____

_____

What are your goals for therapy?_____

_____

Parent/Guardian Signature _____ Date:_____
Relationship to patient: _____