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Supplemental intake

Child's Name:
DOB:

Eating and Drinking

Were there any early feeding problems such as: difficulty nursing, colic, special formula, long feeds, difficulty transitioning to table food, or another issue that caused concern? Please provide details:

_____
_____
_____
_____
_____
_____

Check all that currently apply most of the time and provide any additional observations

_____Takes big bites of food
_____Takes small bites of food
_____Take average bites of food
_____Eats quickly
_____Eats slowly
_____Chews with mouth open
_____Chews with mouth closed
_____Needs liquid to wash down food
_____Belches excessively
_____Digestive problems
_____Eats a variety of food, textures, temperature, and flavor
_____Has a restrictive or limited diet

_____
_____
_____
_____
_____

_____
_____
_____

Oral habits and behaviors

Please check what most typically applies:

_____Lips are together when awake
_____Lips are apart when awake

_____Lips are together when asleep
_____Lips are apart when asleep

_____Lips are together when watching tv
_____Lips are apart when watching tv

_____Lips are together when riding in car
_____Lips are apart when riding in car

Did your child use a pacifier? _____
If yes until what age? _____

Did or does your child have a thumb sucking habit?
If yes, please note duration:
_____
_____
_____

Does your child
Bite on fingernails? _____
Lick lips excessively _____
Chew on pencils/shirts? _____