



Intake Form for Feeding Evaluation

Biographical

Child's Name: _____ Sex: M/F Date of Birth: _____

Mother: _____ Father: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell: _____

Email Address: _____

Other Caregivers (i.e. nanny, daycare provider, etc): _____

Siblings (name & age): _____

Who referred you or how did you find us? _____

Feeding Issues: What is/are your feeding concern(s)? Please describe. _____

What is your feeding goal(s) for your child? _____

Medical Team

Name of Primary Care Physician/Pediatrician: _____

Address: _____

Phone: _____

Name of Gastroenterologist: _____

Address: _____

Phone: _____

Please list any other specialists who are treating your child:

Name: _____

Address: _____

Phone: _____

Is your child in Early Intervention or receiving other therapy? Y/N SLP, OT, PT, RD

Name: _____ Location: _____

Medical Information

Medical Diagnoses: _____

Pregnancy details (circle): Full term Premature Vaginal C-Section

Assisted Birth: N/Y- Forceps/Vacuum Apgar Scores(if known): _____

Complications during pregnancy or during/following delivery: No/Yes _____

Respiratory/Nutritional support: No/Yes _____

Feeding tube? No/Yes (If yes, please complete additional Tube Feeding Intake Form).

Overall Development: Normal/Delayed. If delayed, what areas? _____

Hospitalizations (month/year & reason): _____

Health history: Ear Infections Y/N? how many? _____ ear tubes Y/N?

eczema: where on body? _____ is medication/treatment

given for eczema? _____ Irritability upper resp. infections asthma

seizures pneumonia rash hives strep throat reflux/GERD

Other _____

Current Weight: _____ %ile Current Length/Height: _____ %ile

Is/ has weight gain and/or growth been a concern? Yes No

Medications (prescription and OTC) (name, dose): _____

Vitamin supplement? N/Y Please list kind: _____ Frequency: _____

Swallow Study (MBSS) Date: _____ Results: _____

Endoscopy Date: _____ Results: _____

Gastric Emptying Date: _____ Results: _____

pH probe Date: _____ Results: _____

Upper GI Date: _____ Results: _____

Allergy Testing: Skin Test Date: _____ Results: _____

Blood Test Date: _____ Results: _____

Describe any special diet or food intolerance: _____

Bowel Habits: Constipation? Yes No If yes, do you use any treatments? _____

Frequency of Bowel Movements _____ times per day/week (circle one)

Consistency of stools: _____ Visible Mucous/ Blood? Yes No

Sleep Habits: Does your child sleep well? Yes No hours per night? _____ Does your

child Snore?: Yes No Does he/she take a nap(s)? Yes No, how many hours? _____

Feeding History

Breastfeeding? Yes No How many months? _____

Any difficulties with nursing? _____

Did you see a lactation consultant? _____

Bottle fed : Yes No Breast milk or Formula in bottle? _____

Please list previous and current formulas & describe tolerance: _____

Has anything else been given in the bottle?: _____

Solids: at what age where baby cereals and purees introduced? _____

Any problems? _____

Please circle the Stages of baby food that your child ate/eats: 1st/2nd/3rd/homemade purees/soft solids/table foods Any problems? _____

Does your child have any of the following?

Food Refusal (refusing all or most foods). Age started: _____

Food Selectivity by texture (eating only certain textures) Age started: _____

Food Selectivity by food type (eating a limited variety of foods) Age started: _____

Strong preference for or refusal of certain food temperature, color, brands: _____

Current Meal Pattern

Which meal is your child's best? (breakfast/lunch/dinner? _____ Worst? _____

How long does a 'typical' meal take? _____

Child's current diet: meats/proteins: _____

Fruits: _____

Vegetables: _____

Carbs: _____

Dairy: _____

Desserts/Sweets/Snacks: _____

Other: _____

Please list non-preferred/refused foods/textures/colors: _____

Liquids: Formula: _____ oz./day cup/bottle

Milk: type _____%, _____oz./day cup/bottle

water _____oz./day juice _____oz./ day cup/bottle

other drinks: _____oz./day cup/bottle

Your child's typical meal schedule Number of meals/snacks: _____

Meal times: a.m. _____ p.m. _____

Snack times: _____ or My child grazes throughout the day? Yes No

Feeding Behavior

Does your child experience any of the following with feeding?

Choking Yes/No what types of food? _____

Aspiration Yes/No what types of food? _____

Gagging Yes/No what types of food? _____

Hypersensitive Yes/No what types of food? _____

Coughing Yes/No what types of food? _____

Vomiting Yes/No what types of food? _____

Problem with biting Yes/No what types of food? _____

Difficulty Chewing Yes/No what types of food? _____

Overstuffs mouth Yes/No what types of food? _____

Pocket food Yes/No what types of food? _____

Drooling Yes/No Teeth Grinding: Yes/No

Sweating Yes/No Excessive burping hiccups gas bloat?

Does your child exhibit any of these behaviors at mealtimes? N/Y Circle all that applies.

- Cries or screams Refuses to self-feed Spits food out
- Throws food Eats too fast/slow Refuse to swallow
- Push food/spoon away Does not suck Leave table
- Induces Vomiting Clenches lips shut Pocket Food

Other: _____

Feeding Practices

Who feeds your child? _____

Does your child eat better for a particular feeder? N/Y Who? _____

Do you sit for family meals on a regular basis? _____

Where does your child currently eat (circle all that apply):

- Table/Chair High chair Adult's Lap Infant seat Sofa
- Crib/Bed Car seat Modified Chair Booster
- Roaming- Kitchen/other rooms in the house

Other: _____

What feeding techniques do you use with your child to get him/her to eat?

- Coax _____ Praise _____ Change meal schedule _____ Threaten _____
- Ignore _____ Punish _____ Distract with TV/toys _____
- Force feed _____ Offer reward _____ Send to room/time out _____
- Mini-meals _____ Change foods _____ Allow grazing/roaming _____
- Chase around house with food _____ Provide favorite' foods _____

Other: _____

What do you do if your child refuses to eat/drink? _____

What does your child drink from (circle): Bottle Sippy Cup Open Cup Straw

Is your child able to self-feed? Y/N with utensils? Y/N

How does your child indicate hunger? _____

Is there something we forgot to ask, that you think would be helpful for us to know:

Do you have any concerns about your child's communication development or skills? Yes No

We look forward to meeting you and your child!

7/2019 K Benson-Vogt, SLP: S Hughes, RD