PEDIATRIC
Feeding & Speech
SOLUTIONS

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: _____ Mucous/ Blood

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? _____ Worst? _____
How long does a 'typical' meal take? _____
Child's 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 Yes/No _____

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

__Cries or screams __Refuses to self-feed __Throws food __Spits food out
__Throws food __Eats to fast/slow __Refuse to swallow
__Pushes food away __Does not suck __Leave table _Pocket Food
__Induces Vomiting __Clenches lips shut __Turns away/bat spoon
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 ____ Booster
____ Sofa ____ Crib/Bed ____ Car seat ____ Modified Chair
_____ 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!
2/18 K Benson-Vogt, SLP: S Hughes, RD