Pediatric Feeding & Swallowing Intake Form

Biographical

Child's Name: ______________________ 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): ____

Feeding Issues

What is your major feeding concern? Please describe feeding problem.

____

____

____

____

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

____

____

____

Medical Team

Name of Primary Care Physician/Pediatrician: ______________________________

Address: ____

Phone: ___________________________ Fax: _________________________________

Name of Gastroenterologist: ____

Address: ____

Phone: ___________________________ Fax: _________________________________

Please list any other specialists who are treating your child:

Name: ____

Address: ____

Phone: ___________________________ Fax: _________________________________

Name: ____

Address: ____

Phone: ___________________________ Fax: _________________________________

Is your child participating in an Early Intervention Program? Y/N

If yes, please list therapists involved (i.e. SLP, OT, PT, nutritionist, etc):

Name: ___________________________ Title: ____________________________

Name: ___________________________ Title: ____________________________

Medical Information

Medical Diagnoses:

____

____

Pregnancy details: 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, what age and how long).

____

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

____

____

Hospitalizations (month/year & reason):

____

____

Current Health: Well/Frequent illness (Please circle any that apply):

Ear Infections	Eczema	Irritability	Upper Respiratory Infections
Seizures	Pneumonia	Rotavirus	Aspiration

Other____

Current Weight: ______________ Current Length/Height: ________________

Medications (name, dose): ______________________________________

Vitamin supplement? N/Y Please list kind: ______________ Frequency:__________

Please provide information if your child has had the procedures below:

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:

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

Consistency: __________________ Mucous/ Blood

Feeding History

Breast fed? N/Y   If yes, at what age was your child weaned? NA/Age ___________

If currently breastfeeding, please describe schedule

____

Bottle fed : N/Y   Breast milk/Formula?   Current formula: ______________

____

____

Please indicate your child's typical meal schedule.
Number of meals/snacks: __________ Timing of meals/snacks:________________

Describe sequence in which food/liquids are offered (i.e. liquids first):

____

____

Formula type: Powder/Concentrate/Ready-to-feed
Please describe how you prepare (i.e. 4 oz water, 2 scoops powder):

____

List any previous formulas & describe tolerance:

____

Other fluids presented in bottle:_____________________________________

Solids: at what age where solids introduced? ___________ Any problems? __________

____

Please circle the Stages of baby food that your child ate/eats: 1st/2nd/3rd/Toddler
Any problems? ____

When were table foods introduced? ________________ Any problems? __________

____

Does your child have any of the following? Please indicate when problem started.

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

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

Food Selectivity by Type (eating a limited variety of foods.) Age started: ___________

Oral motor delays (problems with chewing, etc). Age started: _________________

Dysphagia (problems with swallowing). Age started: ______________________

Abnormal preferences (temperature sensitive, color specific, particular brands).
Please describe: ____

Other feeding problems: ____

Current Meal Pattern

Which meal is your child's best? ____________________ Worst? ________________________

How long does a 'typical' meal take? ____

Please List preferred foods:

____

____

____

____

____

Please list non-preferred foods:

____

____

____

____

Feeding Behavior

Does your child experience any of the following with feeding? N/Y

Choking	Yes/No	Difficulty Chewing	Yes/No
Gagging	Yes/No	Coughing	Yes/No
Vomiting	Yes/No	Overstuffs mouth	Yes/No
Drooling	Yes/No	Teeth Grinding	Yes/No
Hypersensitive	Yes/No	Penetration/Aspiration	Yes/No
Sweating	Yes/No	Problem with biting	Yes/No

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

Cries or screams	Messy	Refuses to Self-feed
Spits food out	Throws food	Eats to fast/slow
Plays with food	Picky Eater	Pushes food away
Does not suck	Refuses to swallow	Induces Vomiting
Leaves table	Wants 'down'	Refuses to open mouth
Eats non-food items	Clenches lips shut	Turns away from spoon

Other:

____

Feeding Practices

Who feeds your child?

____

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

____

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

Adult's Lap	Infant seat	High chair	Booster
Table/Chair	Sofa	Crib/Bed	Car seat
Modified Chair	Wheel chair	Tumble form	

Roaming- Kitchen/other rooms in the house

Other: ______________________________

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

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

Other: ______________________________

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

____

____

____

What does your child drink from (circle please):

Bottle   Sippy Cup   Open Cup   Straw

Is your child able to self-feed? Yes/No

Do you think your child feels hunger? Yes/No

How does your child indicate hunger?

____

____

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

____

____

____

____

Signature ______________   Relationship to child ______________   Date ______________

We look forward to seeing your child!