

Pediatric Feeding & Swallowing Solutions Intake Form

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): _____

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: _____

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, please complete additional Tube Feeding Intake Form).

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: _____
	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? 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/Formulation? Current formula: _____

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 were solids introduced? _____ Any problems? _____

Please circle the Stages of baby food that your child ate/eats: 1st/2nd/3rd/Toddler/DICES
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: _____

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): _____

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 | Chase around house with food |

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:

Day Care/School

Name of daycare/school: _____ Director: _____

Address: _____

Phone: _____

What meals are provided? Please circle. Breakfast Snack Lunch Dinner

Do you provide food/beverages? Yes/No

Signature

Relationship to child

Date

We look forward to meeting you and your child !

4/09 K Benson-Vogt, SLP: S Hughes, RD

