SPEECH PATHways FIRST STEPS

speechpathways.net

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 is 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: Y ? N Forceps /V acuum Apgar Scores (if known): _____

Complications during pregnancy or during/following delivery: Y / N

Respiratory/Nutritional support: Y / N

Feeding tube?: Y / N (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? Y / N 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: _____ per day / week (circle one).

Consistency: Mucous / Blood

Feeding History

Breast fed? Y ? N If yes, at what age was your child weaned? _____

If currently breastfeeding, please describe schedule: _____

_____

Bottle fed: Y / N 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. 4oz 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

Any problems? _____

_____

When were table foods introduced? _____

Does your child have any of the following? Please indicate when problems 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?

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

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

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

Other: _____

Feeding Practices

Who feeds your child?: _____

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

Do you think your child feels hunger? Y / N

How does your child indicate hunger? Y / N

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!