**Multidisciplinary Pediatric Feeding Case History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name**: |  |  | **Date of Birth:** |  |
| **Referred by:** |  |  | **Pediatrician**: |  |

***GENERAL QUESTIONS***

1. **Why is your child being seen for a feeding evaluation?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **When did these problems begin?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Has your child received a feeding evaluation in the past?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Has your child received feeding therapy in the past?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **What would you like to see your child accomplish in feeding therapy?**

|  |  |  |
| --- | --- | --- |
| ☐Increase amount of food | ☐Decrease/eliminate tube feeds | ☐Decrease vomiting |
| ☐Increase variety of foods | ☐Increase the textures of food | ☐Resolve reflux/GI issues |
| ☐Improve mealtime behaviors | ☐Improve oral motor skills | ☐Other: |
| ☐Increase weight gain | ☐Decrease gagging |  |

***BIRTH HISTORY***

**Mother’s general health during pregnancy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Were there any complications during pregnancy**? \_\_\_\_\_\_\_\_\_\_\_\_\_If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_

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**Length of Pregnancy**: \_\_\_\_\_\_\_\_\_\_\_ ☐Term. ☐Preterm ☐Length of NICU stay\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth Weight**: \_\_\_\_\_lbs. \_\_\_\_oz. **Type of Delivery**: ☐Head First ☐Feet First ☐Breech ☐ C-Section

**Were any of the following medical conditions present at birth**?

☐cord wrapped around neck ☐jaundice ☐Rh incompatibility ☐respiratory distress ☐heart problems ☐blue color/lack of oxygen ☐sucking/feeding problems ☐motor weakness ☐other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***MEDICAL HISTORY***

**Current medical diagnosis, if applicable:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child ever been hospitalized?** ☐No ☐Yes Please list date/reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications currently taken, including frequency/amount:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your child have a previous history or any current issues with any of the following?**

|  |  |  |  |
| --- | --- | --- | --- |
| Recurrent ear infections |  | Vomiting, frequent spitting up or regurgitation |  |
| Recurrent colds and sinus infections |  | Constipation |  |
| Recurrent ulcers in the mouth |  | Diarrhea |  |
| Frequent choking or gagging |  | Changes in urination (decrease or increase) |  |
| Chronic or recurrent cough |  | Abnormal muscle tone |  |
| Pneumonia |  | Seizures |  |
| Wheezing |  | Delay in development |  |
| Heart problems |  | Sensory issues |  |
| Delayed gastric emptying |  | Factures or broken bones |  |
| Reflux |  | Skin problems |  |
| Nausea or abdominal pain |  | Tongue or lip tie |  |
| Open mouth when awake/sleeping |  | Snoring when sleeping |  |

If yes, please provide additional notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***DENTAL HISTORY***

☐ No Problems ☐Current issues/concerns ☐Regular follow-up with dentist

**Does your child tolerate toothbrushing?** ☐Yes ☐No

If yes, are your child’s teeth currently brushed daily? ☐Yes ☐No

By whom? ☐Child ☐Caregiver ☐Other: \_\_\_\_\_\_\_\_\_\_\_\_

What is your child’s reaction to toothbrushing? ☐Enjoys ☐Resists ☐Other: \_\_\_\_\_\_\_\_\_\_\_\_

If “resists” or “other” was selected, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Does your child have a history of dental carries or tartar buildup?** ☐No ☐Yes

Provide any pertinent information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child been seen by a dentist?** ☐No ☐Yes

Name of dentist, recent dental visit date/results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child had dental surgery?** ☐No ☐Yes

List procedure, date, and pertinent information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child had unusual dental findings?** ☐No ☐Yes

Pleaseexplain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***NUTRITION***

☐ No Problems ☐Current issues/concerns ☐Regular follow-up with nutritionist/RD

**Has your child ever had a nutritional assessment?** ☐No ☐Yes

Name of consultant, date, and pertinent information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Has your child ever had blood tested to determine nutritional deficits?** ☐No ☐Yes

Date of most recent testing and results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Do you or your doctor have concerns about recent weight gain or loss?** ☐No ☐Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have there been any recent changes in appetite?** ☐No ☐Yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are there any concerns about nutrition and variety of food consumed?** ☐No ☐Yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child been tested for food allergies?** ☐No ☐Yes

Please list any food allergies/intolerances that you are aware of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*PLEASE NOTE: IF YOUR CHILD HAS FOOD ALLERGIES THAT REQUIRE AN EPI PEN, PLEASE BE SURE THIS IS PRESENT FOR EVERY SESSION. FOR SAFETY PURPOSES, A FEEDING SESSION WILL NOT TAKE PLACE IF AN EPI PEN IS REQUIRED AND IS NOT PRESENT.

***GASTROINTESTINAL HISTORY***

☐ Not Applicable ☐Current issues/concerns ☐Regular follow-up

***Does your child have a previous history or any current issues of any of the following GI deficits?***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Altered peristalsis |  | Diabetes |  | Reflux |  |
| Bowel obstruction |  | Esophagitis (Eosinophilic) |  | Slow gastric emptying |  |
| Crohn’s disease |  | Esophagitis (general) |  | Short bowel syndrome |  |
| Chronic diarrhea |  | Failure to thrive |  | Vomiting |  |
| Constipation |  | GI bleeding |  | Other: |  |
| Dehydration |  | Hypoglycemia |  | Other: |  |

If yes, please provide additional notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your child have regular bowel movements?** ☐Yes ☐No If no, please comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your child have a history of any GI surgery?** ☐Not applicable

☐Colostomy ☐Fundoplication ☐Pyloromyotomy ☐Short gut ☐Other

If yes, please provide date and additional notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Has your child ever had any of the following tests completed?** ☐Not applicable

☐MBS ☐FEES study ☐Upper GI ☐Barium Swallow

☐pH probe ☐Gastric emptying scan ☐Sialogram ☐Other

If yes, provide the date and additional notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***TUBE FEEDING*** ☐ Not applicable ☐Was tube fed in the past ☐Is currently tube fed

**What type of feeding tube?** ☐NG-tube ☐G-tube ☐J-tube ☐PEG tube ☐PEJ tube

**What type of formula is used?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Where does the tube feed occur?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your child’s reaction to tube feeding?**  ☐Enjoys ☐Resists ☐Other: \_\_\_\_\_\_\_\_\_\_\_\_

If “resists” or “other” was selected, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please detail your child’s tube feeding schedule below.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Time of feeding**  **(start time)** | **Continuous drip, Bolus, or Combination** | **Amount** | **Gravity or Pump** | **Over what time period or what rate** |
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Please provide an additional concerns or information regarding your child’s tube feeds:

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***FEEDING HISTORY***

**What best describes your child’s appetite?** ☐Poor ☐Fair ☐Good ☐Excellent

**How does your child let you know he/she is hungry?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child ever been on any type of special diet?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What formula(s), milk, or milk substitute does your child currently take by mouth?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the amount of formula fed (cc’s or calories/child’s weight)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **Feeding method** | **Age introduced** | **For how long?** | **Problems/Comments** |
| Breast-fed |  |  |  |
| Bottle-fed |  |  |  |
| Finger feeds |  |  |  |
| Spoon |  |  |  |
| Fork |  |  |  |
| Knife |  |  |  |
| Straw drinking |  |  |  |
| Sippy Cup |  |  |  |
| Open Cup |  |  |  |
| Other: |  |  |  |

**Please check the box that describes your child’s intake of each of the following food types:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Consistency** | **Currently Eats** | **Previously Ate** | **Won’t Eat** |
| Regular liquid | ☐ | ☐ | ☐ |
| Thick liquid | ☐ | ☐ | ☐ |
| Stage 1 or 2 baby food | ☐ | ☐ | ☐ |
| Food prepared in blender | ☐ | ☐ | ☐ |
| Ground or Stage 2 baby food | ☐ | ☐ | ☐ |
| Mashed table food | ☐ | ☐ | ☐ |
| Chopped table food | ☐ | ☐ | ☐ |
| Regular table food | ☐ | ☐ | ☐ |
| Crisp food (crackers) | ☐ | ☐ | ☐ |
| Crunchy food (carrot) | ☐ | ☐ | ☐ |
| Chewy food (meat) | ☐ | ☐ | ☐ |

***FOOD PREFERENCES LOG***

|  |  |  |  |
| --- | --- | --- | --- |
| Food Always Eaten | Occasionally Eaten | Used to Eat-  Now refuses | Never eats-  but family typically eat |
|  |  |  |  |
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***MEAL SCHEDULE AND ROUTINE***

**Does your child have a schedule/routine for mealtime?** ☐Yes ☐No

**Please outline your child’s mealtime (any oral intake) schedule based on an average day.**

Example:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Meal | Time |  |  | Meal | Time |
| 1. | Breakfast | 8:00 |  | 1. |  |  |
| 2. | Snack | 10:00 |  | 2. |  |  |
| 3. | Lunch | 12:00 |  | 3. |  |  |
| 4. | Pediasure | 2:00 |  | 4. |  |  |
| 5. | Dinner | 6:00 |  | 5. |  |  |
| 6. | Snack | 7:00 |  | 6. |  |  |
| 7. | Other | 10:00 |  | 7. |  |  |

**Where does your child sit for mealtime?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How long does a meal take?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who typically feeds your child?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***MEALTIME BEHAVIOR***

**Please check any behaviors that are of concern to you.**

|  |  |  |  |
| --- | --- | --- | --- |
| ☐Eats too fast | ☐Eats non-food items | ☐Sneaks or steals food | ☐Eats too slow |
| ☐Eats too much | ☐Uses a bottle | ☐Vomits | ☐Pushes food away |
| ☐Refuses to open mouth | ☐Reflux | ☐Drools | ☐Spits food out |
| ☐Throws or drops food | ☐Eats too little | ☐Messy eater | ☐Cries or tantrums |
| ☐Refuses to swallow | ☐Fails to chew food | ☐Leaves table | ☐Plays with food |
| ☐Picky eater | ☐Gags | ☐Ruminates | ☐Grazes all day |
| ☐Requires distraction | ☐Selective | ☐Other: | ☐Other: |

**Please check any techniques that you have used to get your child to eat.**

|  |  |  |  |
| --- | --- | --- | --- |
| ☐Threaten | ☐Forced feeding | ☐Model | ☐Limit foods |
| ☐Coax | ☐Change food offered | ☐Spank | ☐Offer small meals |
| ☐Offer reward | ☐Distract with play/toys | ☐Praise | ☐Ignore |
| ☐Send to time-out | ☐Change meal schedule | ☐Use TV/Video | ☐Other: |

Please provide an additional concerns or information regarding your child’s feeding history**:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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