FEEDING INTAKE

Please fill out the information below and return either via fax, email, or in person at least 24 hours before your child's consultation.

Date Completed:

A. Identifying and Education information

Child's Name:_____Check one: ___Male ___Female
DOB: _____ Age: _____
Weight:_____ Height:_____
Referring physician and practice:
_____
Primary Diagnosis: _____
Reason for referral: _____
Pediatrician and Practice: _____Phone:_____
Other Specialists (GI, allergist, dietician):_____Phone:_____
Home address: _____
City, State, Zip: _____
Parent/Guardian Name(s): _____
Email: _____
Home phone: _____ Cell phone: _____
Who is filling out this questionnaire? _____Relationship to child: _____
How did you hear about EBS feeding program? _____
Languages spoken at home: _____
Is your child enrolled in any type of childcare facility? Yes No
Name of School/Facility:_____
Date Enrolled: _____ Hours per week: _____ Current Grade:_____
Describe any special assistance or accommodations provided in the educational setting:
_____
_____
Has your child ever had a Feeding/ Speech and Language/ Occupational/ Physical/ Behavioral/ Psychological evaluation? Yes No

If so, circle the type(s) of evaluation they had.
When?_____ Would you mind sharing the results? Yes No

Does your child receive therapy at this time? _____ x/week _____
Where does your child receive these services? _____
Has your child received therapy services in the past? ☐Yes ☐No
Type and Date services ended: _____
Current Height:_____ Current Weight: _____

B. Pertinent past and current medical information

Prenatal/birth history

Length of pregnancy (weeks): _____
Were there any complications during pregnancy or delivery? ☐Yes ☐No
If yes, please explain: _____
Type of Delivery: ☐Vaginal ☐Cesarean section

Hospitalization/surgical history

Date(s): _____
Reason (s) for hospitalization: _____

Diagnostic history

Does your child have any current or past diagnoses?: _____

_____

Developmental Milestones

At approximately what age did your child begin to:

roll over	_____	babble	_____
sit unaided	_____	use words	_____
crawl	_____	combine words	_____
stand unsupported	_____	use sentences	_____
sleep through the night	_____	walk	_____

length of time between crawling and walking _____

Did your child enjoy tummy time or prefer to play in other positions? _____

Known precautions/allergies

Medical allergies: ☐ Latex ☐ Other:
Food allergies: ☐Dairy ☐ Gluten ☐ Nuts ☐ Soy ☐ Other: _____
Does your child require an EpiPen for any allergies? Yes ☐ No ☐
Food intolerances: ☐Dairy ☐Gluten ☐Nuts ☐ Soy ☐ Other: _____

Comments:

_____

Current Medications: ☐ Not applicable (Skip to Next Section)

Medication 1: _____How long been taking?_____

Prescribed for: _____Dosage:_____Time of Day Taken: Morning Afternoon Evening _____ **Medication 2:** _____ How long been taking?_____

Prescribed for: _____Dosage:_____Time of Day Taken: Morning Afternoon Evening

Medication 3: _____ How long been taking?_____

Prescribed for: _____Dosage:_____Time of Day Taken: Morning Afternoon Evening

Additional Medications:

_____

Neurologic History/Current Concerns ☐ Not applicable (Skip to Next Section)

HISTORY of neurologic deficits? ☐ Yes ☐No

If yes, please check:

☐ Abnormal Muscular Tone (high) ☐ Abnormal Muscular Tone (low) ☐ Anoxia ☐ Ataxia ☐ Brain tumor ☐ Hydrocephalus ☐ Microcephaly ☐ Paralysis ☐ Seizures ☐ Stroke ☐ TIAs ☐ Tremor ☐ Other: _____

If any box checked, please explain:_____

CURRENT Neurologic Status**:** No problems ☐

☐ Current issue(s) ☐ Regular follow-up with neurologist

If current issues please explain:

_____

Cardiac History/Current Concerns ☐ Not applicable (Skip to Next Section)

HISTORY of heart problems? ☐Yes □ ☐No

If yes, please indicate the specific heart problem or suspected problem:

Please check if any of the following **have** occurred:

☐ Surgery ☐Episodes of cyanosis ☐Altered activity level ☐Intolerance of specific positions secondary to cardiac condition

Known complications from cardiac condition: ☐ CVAs ☐TIAs ☐Vocal fold paralysis ☐Other

If any box checked, please explain:

_____

CURRENT cardiac status: ☐ No problems ☐ Current issue(s) ☐ Regular follow-up with cardiologist
Physician Name: _____

If current issues please explain:
_____

Respiratory History/Current Respiratory Concerns Not applicable (Skip to Next Section)
HISTORY of respiratory problems: (check all that apply)
☐Apnea (Obstructive) ☐ Apnea (Central) ☐ Asthma ☐Bronchitis/bronchiolitis
☐ Bronchopulmonary Dysplasia (BPD) ☐ Malacia (broncho) ☐Malacia (laryngo) ☐ Malacia (tracheo)
☐ Nasal/Chest Congestion ☐ Pneumonia ☐ Tracheal stenosis ☐ Wheezing ☐ Other: _____
If pneumonia, how many times? _____
Was it ever classified as aspiration pneumonia? ☐ Yes ☐No
If yes, please explain: _____
Approximate number of colds per year: ☐ Normal ☐ Above average
Approximate number of upper respiratory infections per year: _____
Tracheostomy tube? ☐Yes ☐ No
If yes (history of tracheostomy tube), please answer the following: Reason for trach AND length of time child had the trach: _____
Complications related to the trach (granuloma tissue build-up, etc.): ☐Yes ☐No
If yes, please explain:
_____

Gastrointestinal History/Current Gastrointestinal (GI) Concerns Not applicable (Skip to Next Section)
HISTORY of GI problems/concerns? ☐Yes ☐ No
If yes, check all that apply: ☐ Altered peristalsis ☐Bowel obstruction ☐ Crohn's Disease ☐ Chronic diarrhea
☐ Constipation ☐ Dehydration ☐ Diabetes ☐ Esophagitis ☐ (Eosinophilic) Esophagitis (general)
☐ Failure to thrive ☐ GI bleeding ☐ Hypoglycemia ☐ Reflux ☐ Slow gastric emptying
☐ Short bowel syndrome ☐ Vomiting ☐ Other: _____
If yes, please provide additional notes: _____
HISTORY of GI surgery: Yes No
If yes, check all that apply: ☐Colostomy ☐Fundoplication ☐Pyloromyotomy ☐ Short gut

Did your child ever receive any alternative feeds? Yes ☐ No ☐

If yes, please select (all that apply): NG-tube G-tube J-tube PEG tube PEJ tube TPN
Other: _____
Type of feeding received: Bolus Continuous drip Combination Other _____

Has your child ever had any of the following tests completed?
MBS FEES study Upper GI Barium Swallow pH probe Sialogram Other: _____
If so, please indicate the dates and results of tests. If multiple tests completed only provide the most recent:
_____

Early oral feeding trials: Chronology of formulas (if child less than 3, please indicate all formulas used and approximate month each formula began) and comments on tolerance:

_____

When was baby cereal introduced? What type? _____

CURRENT GI status (check all that apply): No problems Current issues Regular follow-up with gastroenterology
Physician's Name:_____
Regular follow-up with pediatrician for GI issues: Yes No
Do you or your doctor have concerns about recent weight gain or weight loss: Yes No
If yes, please explain:

_____

Has your child ever had a nutritional consult? Yes No
If yes, please provide the name of consultant and date last visited with any pertinent comments:

_____

Has your child ever had blood tested to determine nutritional deficits? Yes No
If yes, please provide date of most recent testing and results:

_____

If your child currently has reflux, have you ever noted coughing or a "gurgly" voice after the episode?
Yes No
If your child currently suffers from recurrent vomiting, approximately how many times daily do they vomit?

_____

Is your child currently receiving tube feeds? Yes No

If yes, check all that apply: NG tube PEG tube PEJ tube G tube J tube Other: _____
Current rate: _____

Current schedule: _____

Additional current GI issues, please explain:

_____

Craniofacial history/Current Craniofacial Concerns Not applicable (Skip to Next Section)
HISTORY: Has your child ever had any known defects of the lip and/or palate? Yes ☐ No ☐
If yes, please explain:

_____

Does your child have a diagnosed syndrome, association, or sequence? Yes ☐ No ☐
If yes, please explain:

_____

History of sinus infections? ☐Yes ☐No
History of resonance pattern deficits? ☐Yes ☐No
History of surgical repair(s) ☐Yes ☐No
If yes or want to add additional comments, please provide below:

_____

CURRENT craniofacial status (check all that apply): ☐ No problems ☐ Current issues ☐
Regular follow-up with (check all that apply): ☐ genetics ☐ plastic surgery ☐ ENT
Do you ever notice food or liquid coming out of the nose? ☐ Yes ☐No
If yes, please select:
Frequency? ☐ Every meal ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely ☐ Other:_____
Type of consistency? ☐ Thin Liquids ☐ Thick liquids ☐ Puree ☐ Solids ☐ With straw use? ☐ Yes ☐ No
Position(s) of the child? (Seated, laying, etc.)

_____

If additional current problems, please explain:

_____

Dental History/Current Dental Concerns History Has your child ever been to the dentist? ☐ Yes ☐ No
Most recent dental visit and results:

_____

Has your child ever had dental surgery or any unusual dental findings? ☐Yes ☐ No
If yes, please explain:

_____

CURRENT dental status (check all that apply): ☐No problems ☐ Current issues
☐ Regular follow-up with dentist/orthodontist
Does your child have normal dentition (number/placement of the teeth)? ☐ Yes ☐ No
If yes to either of the previous questions, please explain:

_____

Are your child's teeth currently brushed daily? ☐No ☐ Yes
By whom? ☐ Child ☐ Parent/Caregiver ☐ Other: _____
Reaction to tooth brushing: ☐Enjoys ☐Resists ☐ Other: _____
If selected "resists" or "other", please explain:

_____

Before leaving medical history, are any additional medical specialists involved with child (check all that apply):
Dermatology ☐ Psychiatry ☐ Psychology ☐ Other: _____
If yes, please explain:

_____

C. Current Nutritional Status/Feeding History/Responses to Food/Current Skills

a. Current oral feeds volume: ☐ Exclusive (all nutrition received by mouth)
☐ Partial supplementation with tube ☐"Tastes" (for pleasure/stimulation/exposure) ☐ N/A

b. For LIQUIDS, please answer the following questions:
Does your child require the liquids to be thickened? ☐ Yes ☐ No
If yes, please indicate degree liquids are thickened and recipe used:

_____

If yes, please indicate the length of time your child has been on thickened liquids:

_____

Does your child CURRENTLY take any liquids orally that do not have to be thickened? ☐ Yes ☐ No
If yes, please answer the following questions:

First took/used	**Current Use**
Breast N/A Age:	Takes/uses now? ☐Yes ☐No If no, age stopped
Bottle N/A Age:	Takes/uses now? ☐Yes ☐No If no, age stopped
No-spill cup N/A Age:	Takes/uses now? ☐Yes ☐No If no, age stopped
Straw N/A Age:	Takes/uses now? ☐Yes ☐No If no, age stopped
Open cup N/A Age:	Takes/uses now? ☐Yes ☐No

	If no, age stopped
Other N/A Age:	Takes/uses now? ☐Yes ☐No If no, age stopped

How many ounces of fluid does your child consume daily?: _____
Does your child ever cough or choke with liquids? ☐Yes ☐ No
Does your child ever sound gurgly while drinking or immediately after? ☐ Yes ☐ No
If yes, please comment:_____
Please select the types of liquid that are regularly consumed:
☐Water ☐ Breast milk ☐ Formula ☐ Milk ☐ Juice ☐ Soda ☐ Yogurt drinks
Other: _____

Comment on any preferences of a specific brand of nipple or cup:

If your child has at any time been breastfed, please indicate ☐ Yes ☐No

Please describe the breastfeeding experience:
_____

For FOODS, please answer the following questions:
Does your child **CURRENTLY** take any foods orally? Yes ☐ No ☐
If no, and never did, please go to section on smell and taste; Otherwise please answer the following questions.

First took/used	**Current Use**
Spoon (by caregiver) N/A Age: Age baby cereal introduced: Age purees introduced:	Now? Yes ☐ No ☐ Comment:
Fingers (by caregiver) N/A Age: First finger foods:	Now? Yes ☐ No ☐ Comment:
Utensils (self) N/A Age:	Now? Yes ☐ No ☐ Comment:
Fingers (self) N/A Age:	Now? Yes ☐ No ☐ Comment:
Other N/A Age:	Now? Yes ☐ No ☐ Comment:

How many ounces of food (approximately) does your child orally consume daily?_____
Does your child ever cough or choke with food? □ Yes □ No
Does your child ever sound" gurgly" while eating or immediately after? □ Yes □ No
If yes, please comment: _____

Please select the types of food consistency (select all that apply) that is regularly consumed:
□ Thin puree (e.g. baby food apricots) □ Puree (e.g. pudding) □ Dissolvable solids (e.g. puffs)
□Soft solids (e.g. cheese, raisins) □ Hard solids (e.g. cookies, dry cereal) □ Multiple consistencies (e.g. dry cereal with milk) □ Difficult to chew foods (e.g. meat, raw vegetables) □Other : _____
Does your child require any specialized feeding equipment? □ Yes □ No
If yes please comment:
_____
Please select the **variety** of foods that your child will eat:
Fruits: □ None □ 1-2 □ 3-4 □ More than 5;
Comment:_____
Vegetables □ None □1-2 □ 3-4 □ More than 5;
Comment: _____
Grains □ None □ 1-2 □ 3-4 □ More than 5;
Comment:_____
Dairy □ None □ 1-2 □ 3-4 □ More than 5;
Comment:_____
Meats □ None □ 1-2 □ 3-4 □ More than 5;
Comment:_____
Do you or your doctor have any concerns regarding the variety of foods that your child will eat? □Yes □ No
If yes, please comment: _____
Would you consider your child to be a "picky" eater? □Yes □ No
Does your child prefer foods that are: Room temperature □ Hot □ Cold

Smell and Sensitivities

Smell:	□Typical	□Unknown	□Heightened	□Diminished
Taste:	□Typical	□Unknown	□Heightened	□Diminished
Preference:	□Sweet	□Bitter	□Strong	□Sour
	□Salty	□Other		

Would you say that your child gags easily with different foods? □Yes □ No
If yes, please explain: _____

Do you prepare special meals? □ Yes □No
If yes, how many meals per day? _____
Do you feel you to have play games to distract your child to get them to eat? □Yes □ No
If yes, how frequently do you have to use this distraction? _____

Behavioral Observations
Do you feel you must reward the child to get them to eat? (i. e. airplane game, clapping, bubbles) □Yes □ No
If yes, how frequently are the rewards used? _____
Do you notice a difference in how much your child eats or how long they stay engaged based on who may be feeding them or different environments? □Yes □ No
If yes, please explain:
_____

Is there one person who is a primary feeder, or one who is most successful at feeding your child? □Yes □ No
If so, who?_____

Activities engaged in prior to mealtime:

□breakfast: _____

□lunch: _____

□dinner: _____

□snacks: _____

How do they transition to mealtime?: □ verbal warning □ physical prompt to table □ timer □ other
Does your child display any behavior problems during mealtimes? □Yes □No

Where are meals eaten?: □ kitchen/dining room table □ separate table □ high chair □ coffee table □ floor □ other

How are meals presented?: □ all food on plate □ no plate-all food □ plate- one food at a time □ no plate-one food at a time □ self-serve

Are choices offered during mealtime?: □ yes □ no
If yes, what choices are given?: _____

Who is typically present during mealtime? (i.e. parents, siblings, peers, etc)
_____

If yes, please specify:

- ☐ Throws Food
- ☐ Spits Food
- ☐ Cries, screams
- ☐ Have difficulty sitting at the table
- ☐ Pushing food/plate away
- ☐ Tantrum
- ☐ Elopement
- ☐ Takes food from others
- ☐ Overeats
- ☐ Leaves the table before finished
- ☐ Verbal Refusal
- ☐ Aggression
- ☐ Holding food in mouth
- ☐ Self-injurious behavior

Behaviors are present when asked to:

- ☐ sit at the table
- ☐ drink liquid presented
- ☐ eat food presented
- ☐ unsure

Meals where behaviors are present: ☐ breakfast ☐ lunch ☐ dinner ☐ snacks

Where are behaviors occurring during mealtime?: ☐ home ☐ school ☐ public/restaurant ☐ other:

Duration of behaviors:

How many meals does your child eat per day? _____

How long does each meal take? _____

Does your child "graze" throughout the day instead of having a meal? If so, please describe.

_____

Does your child have any other behavioral issues outside of feeding? If so, please describe:

_____

What are you hoping to gain from feeding therapy?

_____