Patient name: _____
Patient DOB: _____

Feeding Evaluation Intake Form

In addition to the Developmental and Medical History intake form for your child's age, please complete the following if your child is being seen for a feeding evaluation.

GI MEDICAL HISTORY:

Is your child followed by a Gastroenterologist? YES/NO
If yes, please list MD: _____

Please check any of the following procedures your child has had performed and date:

☐	Swallow Study	☐	Endoscopy
☐	Gastric Emptying	☐	Upper GI
☐	pH probe	☐	Skin Test
☐	Allergy Testing	☐	Blood Test

Please provide any relevant findings from the above procedures performed pertaining to your child's feeding:

Has your child ever been administered a feeding tube? YES/NO
If so, when and why?

Has your child previously received therapy to address feeding difficulties? YES/NO
If yes, please list where and for what length of time:

How did your child respond to therapy?

For what reason was this therapy discontinued?

BOWEL HABITS:

Frequency of Bowel Movement: _____times per (circle one): DAY WEEK

Consistency: (please circle) HARD SOFT LOOSE WATERY

Has your child ever been diagnosed with constipation?

If yes, is he or she taking medication to help? YES/NO Name of Medication: _____

EARLY FEEDING HISTORY

Was your child breast fed? YES NO
For how long?

Did your child latch on easily? Have a strong or weak suck? Lose liquid out the corners of the mouth?
Please describe:

Was your child bottle fed? YES NO

From when to when:

What brand nipple and size did/do you use:

Have you ever switched nipples? Why?

If your child drinks formula, what kind?

Has your child ever had to change formulas? If yes, why?

Please describe your child's current skill on breast or bottle:

If your child is weaned, please describe how the weaning process off the breast and/or bottle went and why the child was weaned:

During these early feedings, did your child exhibit any of the following behaviors? Please check all that apply:

☐Arch ☐Cry ☐Spit up ☐Gag ☐Vomit ☐Cough ☐Pull off nipple

Please describe when they would happen, why, or for how long:

Has your child ever been diagnosed with reflux? YES/NO

If yes, was medication prescribed? YES/NO Name of medication: _____

Was the medication helpful? YES/NO

How long was your child on medication? _____

Does your child sleep through the night? YES/NO

Does your child eat/drink during the night? YES/NO

Does your child snore, cough or cry at night? YES/NO

At what age did your child transition to:

Baby cereal?_____ Baby food?_____

Finger foods?_____ Transition fully to table food?_____

Please describe how these transitions were handled by your child, especially if there were difficulties:

FOOD PREFERENCES:

List any foods your child is allergic to:

How would you describe your child's appetite?

☐poor ☐fair ☐good ☐excellent ☐overeats

How does your child indicate hunger?

Do your child's habits and preferences match any family member's habits? **YES/NO**
If yes, who and what habit or preference:

Does your child eat little meals and snacks throughout the day? **YES/NO**

Please list typical mealtimes:

Breakfast:
Lunch:
Dinner:
Snacks:

If you were to put the meal into a measuring cup, how much is eaten per meal?

List the foods your child refuses:

FOOD CONSISTENCY: please check all that are currently applicable

	Does Eat	Can Eat	Never Eats	Can't Eat	Has not Tried
liquid/soups	☐	☐	☐	☐	☐
strained baby food	☐	☐	☐	☐	☐
junior baby food	☐	☐	☐	☐	☐
creamy foods (ice cream/yogurt)	☐	☐	☐	☐	☐
blended table food –puree (blender/mixer)	☐	☐	☐	☐	☐
mashed table food	☐	☐	☐	☐	☐
chopped table food	☐	☐	☐	☐	☐
regular table food	☐	☐	☐	☐	☐
crispy foods (chips, crackers)	☐	☐	☐	☐	☐
chewy foods (meat)	☐	☐	☐	☐	☐
crunchy foods (carrots, celery)	☐	☐	☐	☐	☐

Please list foods consistently accepted:

fruits	
meats	
breads/cereals	
vegetables	
dairy products	
sweets	
other	

Special Diets
☐Kosher
☐Gluten Free
☐Casein Free
☐Vegetarian
☐Vegan

MEALTIME:

Describe your child's mealtime:

Who usually feeds your child?

Who typically eats with your child?

How long are meals typically?
☐less than 10 minutes ☐10-20 minutes ☐20-30 minutes ☐30-60 minutes ☐Over 60 minutes

How is the child positioned for feeding?
☐Chair at table ☐Booster Seat ☐Highchair ☐Reclined ☐Adult's lap

☐Adaptive Chair: please list type _____

How is the child fed?
☐Drinks from bottle ☐Fed by parents ☐Feeds self with fingers ☐Feeds self with spoon ☐Feeds self with fork ☐Uses knife ☐Drinks from open cup ☐Drinks from straw ☐Drinks from sippy

Please check all behaviors that are problematic during mealtime

☐	Throws food	☐	Takes food from others
☐	Spits food	☐	Aggressive towards others present at table
☐	Cries, screams	☐	Refuses food
☐	Only eats specific foods	☐	Overeats
☐	Pushes over table or chair	☐	Consumes too fast
☐	Throws utensils or other dinner ware	☐	Hits self
☐	Messy eater	☐	Scratches self
☐	Elopes from table	☐	Bites self
Other:			

What do you do when your child has behavior problems during mealtime?

ORAL MOTOR HISTORY:

Did/Does your child often place toys, items, or fingers in his or her mouth? YES/NO
Does your child drool excessively? YES/NO
Does your child grind his or her teeth? YES/NO
Does your child allow you to brush his or her teeth? YES/NO
Has your child been diagnosed with lip/tongue tie? YES/NO
If yes, has the lip or tongue tie been corrected? YES/NO Date: _____

3 DAY FOOD LOG

By completing this food log, it will provide the evaluating therapist with an in depth picture of your child's eating habits. Please complete this food log and bring with you to the evaluation. Thank you ☺

Name:_____ Date of Birth:_____

DATE:

BREAKFAST	AM SNACK	LUNCH	PM SNACK	DINNER
Time	Time	Time	Time	Time

DATE:

BREAKFAST	SNACK	LUNCH	SNACK	DINNER
Time	Time	Time	Time	Time

DATE:

BREAKFAST	SNACK	LUNCH	SNACK	DINNER
Time	Time	Time	Time	Time