Pediatric Feeding Intake Form

Biographical Information

Child's Name: ___________________________ Sex: M/F

Date of Birth/Age: ________________ Parents Names:________________

Address: ___________________________ Address: ___________________________

City, State, Zip: _____________________ City, State, Zip: _____________________

Home Phone: _____________________ Home Phone: _____________________

Cell Phone: ____________________ Cell Phone:____________________

Email Address: _____________________________________________________________________________

Who can I thank for this referral? : ____________________________________

What is your major feeding concern? Please describe feeding problem.
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

What is your feeding goal(s) for your child?
_________________________________________________________________________________________

________________________________________________________________________________________

Name of Primary Care Physician/Pediatrician: Name of Gastroenterologist:

Phone: ___________________________________ Phone: ___________________________________

Fax: _____________________________________ Fax: _____________________________________

Please list any other specialists who are treating your child:

Name: ________________________ Phone: _________________ Fax: ______________________________

Name: ________________________ 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:
_____________________________________________________________________________________________
____________________________________________________________________________________

Prenatal/birth history

Length of pregnancy (weeks): ______________________

Were there any complications during pregnancy or delivery? Yes, No

If yes, please explain:

________________________________________________________________________________
____________________________________________________

Pregnancy details: Full term/Premature   Vaginal/C-Section

Complications following delivery: No/Yes
_________________________________________________________
__________________________________________________________

__________________________________________________________

Birth Weight_________________________ Current weigh/Height: ___________________

Hospitalization/surgical history

Date(s): ________________________

Reason (s) for hospitalization:

________________________________________________________________________________
________________________________________________________________________________
_______________________________________________________________________________

Known precautions/allergies

Medical allergies: _____________________________

Food allergies:  ________________________________

________________________________________________________________________________

Please Circle Current Medications / Not currently taking medications

Medication 1: _____________________How long? _________________

Prescribed for: _________________________________________________

Medication 2: _____________________________How long? ________________

Prescribed for: ____________________________________________

Medication 3: ________________How long? ______________

Prescribed for: ___________________________________________

Additional Medications:

________________________________________________________________________________
____________________________________________________

**Gastrointestinal History/Current Gastrointestinal (GI): Concerns   Not applicable**

HISTORY of Reflux/ GERD? Yes   No

If yes, check all that apply:

- Spitting up
- Arching
- Failure to thrive
- Burping
- Coughing
- Seeming desire to eat then refuses
- Slow gastric emptying
- Vomiting
- Drooling
- Chronic diarrhea
- Constipation
- Dehydration
- General discomfort when eating

Please provide additional notes: ______________________________________________

HISTORY of GI surgery: Yes, No

If yes, please explain: ___________________________________________________________

Did your child ever receive any alternative feeds? Yes        No

If yes, please select (all that apply):

- NG-tube
- G-tube
- J-tube
- TPN Other: ___________________

Type of feeding received:  Bolus Continuous Combination Other

Please Describe Feeding Schedule

__________________________________________________________________________________
__________________________________________________________________________________
_____________________________________________________

ENT: (Please circle  any that apply.

- Ear Infections
- Aspiration
- Bronchitis

Pneumonia
Coughing /choking episodes when eating.
Upper Respiratory Infections

Bowel Habits:

Frequency of Bowel Movements _______ times  per day/week (circle one).

Consistency: (hard, soft,) ___________________

Feeding History.  Breast Fed N/Y If yes, at what age was your child weaned? NA/Age

Bottle fed: N/Y Breast milk/Formula? Current formula: ____________________________

Formula type: Powder/Concentrate/Ready-to-feed.
_______________________________________________________________
_______________________________________________________________

List any previous formulas & describe tolerance:
_______________________________________________________________
_______________________________________________________________

Other fluids presented in bottle: _________________________________________________________

Solids: at what age where cereals/ baby foods introduced? _____________
_______________________________________________________________

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

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 textures that are NOT age appropriate) Age started: _________

Food Selectivity by Type (eating a limited variety of foods). Age started: ________

Food Selectivity by Smell or Touch. Age started: ________

Oral motor delays (problems with chewing, etc.). Age started: ___________

Dysphagia (problems with swallowing/coughing choking). 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/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?

Choking Yes/No Overstuffs mouth Yes /No
Drooling Yes/No Teeth Grinding Yes/No
Hypersensitive Yes/No Problem with biting Yes/No
Sweating Yes/No Gagging Yes/No
Chewing Yes/No Vomiting Yes/No
Coughing Yes/No Hx of: Aspiration/Penetration
Other_________________________________________________________________

Feeding Behavior Does your child exhibit any of these behaviors at mealtimes?

N/Y Circle all that apply.

- Cries or screams Messy Refuses to Self-feed Spits food out
- Throws food Eats too fast/slow Plays with food Picky Eater
- Pushes food away Pockets Foods in Cheeks Refuses to swallow Induces Vomiting
- Leaves table Wants 'down Refuses to open mouth Eats non-food items
- Clenches lips Shuts Down Turns away from spoon Refuses to self-feed

Refuses to touch certain foods

Other: _____________________________________________________________________

Where does your child currently eat (circle all that apply)

Adult's Lap Infant seat High chair Booster 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.

Please Describe:
___________________________________________________________________________

____________________________________________________________________________

What does your child drink from (circle please): Bottle Sippy Cup Open Cup Straw

Is your child able to self-feed? Yes/No

_____________________ ___________________

Signature Date

I look forward to meeting you and your child.