HOLLY SPRINGS
feeding & speech

SCHOOL AGE / ADOLESCENT FEEDING INTAKE FORM

PATIENT INFORMATION *Referred by:* _____

Child's Name: _____ DOB: _____ Age: _____ M / F

Parent/Caregiver NAME_____ DOB_____

Parent/ Caregiver NAME_____ DOB_____

Address: _____ Address (if different):_____

City/State/Zip: _____ City/State/Zip: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Email Address: _____

Name of Primary Care Physician/Pediatrician: _____

Phone: _____ Fax: _____

Please list any other specialists who are treating your child:

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax:_____

Other Special Services (i.e., IEP, other therapies, etc.): **Y / N**
If yes, explain: _____

_____

Language(s) Spoken at Home: _____ Preferred Language: _____

AREA OF CONCERN(S)

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

_____

_____

_____

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

_____

_____

BIRTH HISTORY

Full Term / Premature (# weeks early: ____) Complications: _____

NICU Stay (if yes, how long?): _____ Ventilator: Y / N Feeding Tube: Y / N

Delivery Type: Vaginal / C-Section Birth Weight: _____

MEDICAL INFORMATION

Medical Diagnoses: _____

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Known Precautions/Allergies:

Medical allergies: _____ Food allergies: _____

Medications / Supplements (dose/how often): _____

_____

Surgeries/Hospitalizations (date): _____

Please Check **YES/NO/NA** and leave comment if applicable for the following:

	YES	NO	N/A	Comment
CARDIOVASCULAR				
Heart murmur				
Heart palpitations				
High blood pressure				
Eye, Ear, Nose, Throat				
Recurrent ear infections				
Hearing difficulties				
Runny nose / drainage				
Recurrent sinus infections				
Enlarged tonsils				
Trouble swallowing				
Allergies				
Vision difficulties				
GASTROINTESTINAL				
Constipation				
Diarrhea				
Reflux				
Nausea/Vomitting				
Bloating				
Abdominal Pain				
RESPIRATORY				
Difficulty Breathing				
Wheezing				
Pain with breathing				
Chronic Cough				
Asthma				
NEUROLOGICAL/PHYSCOLOGICAL				
Headaches/Migraines				
Dizziness				
Fainting				
Anxiety				
Depression				
OTHER (EXPLAIN)				

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Bowel Habits:
Frequency of Bowel Movements - (#)_____ times per day / week (circle)
Consistency (hard/soft/etc):_____ Other:_____

FEEDING CONCERNS / HISTORY:

How is your child positioned when eating? (ex. sitting in high chair, on the floor, standing)
_____

Are there any other activities going on during meal time? (ex. TV, toys) _____

Who else is present for meals? _____

If your child does not feed him/herself, who feeds him/her? _____

Does your child eat more/ less, or different types of foods when he/she is fed by someone else or in a different location? Y / N If so, please describe _____

How many times a day does your child eat? _____

Approximately how much liquid does your child drink at each meal? _____

Approximately how much food does your child eat at each meal? _____

What sequence is followed when offering foods and liquids at mealtimes? _____

_____

How long do meals take to complete? _____

How would you describe your child's appetite? (circle) Strong Variable Poor

How does your child show that they are hungry? _____

Please list preferred/easy foods your child eats: _____

Please list non-preferred/difficult foods: _____

Please Check All That Apply Below:

Behaviors When Eating	Food and Liquid Types	Feeding Utensils
□ crying	□ Regular Liquids	□ Bottle
□ gagging	□ Thickened Liquids	□ Sippy Cup
□ vomitting	□Baby Food — Stage 1 / 2/ 3	□ Open Cup Cup
□ coughing	□ Soft Mashable table foods	□ Straw
□ spitting food out of mouth	□ Dissolvable, Crunchy Foods	□ Spoon
□ regurgitating food	□ Regular Table Food	□ Fork
□ holding food in mouth		□ Finger Feeding
□ getting down from table		
□ complaining of food stuck (in throat/chest) / pain		
□ chewing too slow / too fast		
□ refusing to touch foods		
□feeling full after a small amount		
□ picky eater		
□other (please list):		

SCHOOL AGE / ADOLESCENT FEEDING INTAKE FORM

What techniques have you used / do you use with your child to get him / her to eat? Describe:

_____

_____

Feeding Schedule - complete as applicable:

Breakfast - Time/Where: _____
AM Snack- Time/Where: _____
Lunch- Time/Where: _____
PM Snack- Time/Where: _____
Dinner- Time/Where: _____
After Dinner Snack - Time/Where: _____
Additional Meals (explain) - Time/Where: _____

Is there any other information that you would like to share that you feel would be beneficial? _____

_____

Thank you for taking the time to complete your child's history form. We look forward to working with your family and thank you for choosing Holly Springs Feeding and Speech to help meet your child's needs.

Parent/Guardian Signature: _____ Date: _____