HOLLY SPRINGS
feeding & speech

PEDIATRIC FEEDING INTAKE FORM

PATIENT INFORMATION *Referred by:* _____

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

Parent/Caregiver 1 NAME_____ DOB_____ Occupation _____

Parent/Caregiver 2 NAME_____ DOB_____ Occupation _____

Address: _____ Address (if different):_____

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

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Email Address: _____

Primary Care Physician/Pediatrician: _____ Phone_____

Please list any other specialists who are treating your child:

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Other Special Services (i.e., IFSP, 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

Adopted? **Y / N** (*circle) - If Yes, at what age? From where?* _____ Foster? **Y / N** *(circle)*

Full Term / Premature (# weeks early: ____) Delivery Type: Vaginal / C-Section Birth Weight: _____

Complications: _____

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

Mother's Gestational Health (describe)_____

Drugs/Alcohol/Medication consumed during pregnancy? **Y / N** (*circle) - If Yes, explain:*_____

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MEDICAL INFORMATION

Medical Diagnoses: _____

Known Precautions/Allergies: ☐No Known Allergies

Medical allergies: _____ Food allergies: _____

Other Precautions: _____

Medications / Supplements (dose/how often): _____

_____

Surgeries/Hospitalizations (date/reason): _____

_____

- GENERAL MEDICAL HISTORY :

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

	YES	NO	N/A		YES	NO	N/A
CARDIOVASCULAR				**RESPIRATORY**			
Heart murmur				Difficulty Breathing			
Heart palpitations				Wheezing			
High blood pressure				Pain with breathing			
EYE, EAR, NOSE, THROAT				Chronic Cough			
Recurrent ear infections				Asthma			
Hearing difficulties				**NEUROLOGICAL/PSYCHOLOGICAL**			
Runny nose / drainage				Headaches/Migraines			
Recurrent sinus infections				Dizziness			
Enlarged tonsils				Fainting			
Trouble swallowing				Anxiety			
Allergies				Depression			
Vision difficulties				**OTHER (explain)**			

If yes for any checked areas above, please explain: _____

_____

- GASTROINTESTINAL HISTORY :

Does your child have a history of Reflux / GERD **Y / N** (circle) - *check all that apply*

☐spitting up ☐ arching ☐failure to thrive ☐burping ☐coughing ☐vomiting
☐drooling ☐constipation ☐ chronic diarrhea ☐ dehydration ☐ slow gastric emptying
☐seeming to desire to eat, but refuses ☐ general discomfort when eating
☐other: _____

Bowel Habits:
Frequency of Bowel Movements - (#)_____ times per day / week (circle)

Consistency (hard/soft/Other) :_____

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FEEDING CONCERNS / HISTORY:

Breast Fed? **Y / N / NA -** If yes, at what age was your child weaned?_____

Bottle fed: **Y / N / NA -** Breast milk/Formula - Current/Previous Formula type: Powder/Concentrate/Ready-to-feed.

List any previous formulas /liquids & describe tolerance: _____

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? **Y / N**
if yes, explain: _____

How/Where 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 indicate if your child has difficulty with the following and what age these difficulties began:

Concern	Age Began	Describe (if applicable)
☐ Food Refusal (refusing all or most foods)		
☐ Food Selectivity by texture		
☐ Food Selectivity by Type (eating a limited variety of foods)		
☐ Food Selectivity by Smell or Touch		
☐ Abnormal preferences (temperature sensitive, color specific, particular brands)		
☐ Oral motor delays (problems with chewing, etc.)		
☐ Dysphagia (problems with swallowing/coughing choking)		
☐ Other		

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Please Check All That Apply Below:

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

Approximately How much liquid does your child consume daily? _____

What meal appears to be your child's best? _____ Worst? _____

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: _____

-Oral Behaviors: Indicate if your child presents with any of the following:

☐Pacifier - if yes, which pacifier: _____
☐ Thumb Sucking
☐Putting other non-food items in their mouth (explain): _____

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: _____