Pediatric Feeding & Swallowing

Supplemental Intake Form

Biographical

Child's Name: _____Date of Birth: _____

Feeding Issues

What is your child's current weight and height:_____

Has your child's growth rate been:

- ○ Slow
- ○ Average
- ○ Above Average

What is your major feeding concern?

Please Describe:

Has your child participated in feeding therapy in the past? YES/NO

If YES, please describe location, therapist, frequency, strategies and results:

What are your feeding goals for your child?

- ○ Increase volume of food/liquids
- ○ Increase variety of foods/liquids
- ○ Decrease/eliminate tube feedings
- ○ Increase the textures of food
- ○ Decrease vomiting related to eating
- ○ Improve mealtime behaviors
- ○ increased weight gain
- ○ Improve oral motor skills
- ○ Decrease gagging during eating
- ○ Other: _____

Additional Medical information

Does your child have current or past cranial facial issues (cleft palate, cleft lip, sub-mucous cleft, recessed jaw, etc.)? YES/NO

Please Describe:

Does your child have current or past cardiac (heart) issues? YES/NO

Please Describe:

Does your child need respiratory (breathing) support? YES/NO

- O Tracheostomy
- O Mechanical ventilation
- O Breathing Treatments
- O Oxygen
- O Other _____

Please Describe:

Does your child need nutritional support? YES/NO

- O Calorie boosters
- O Specialized supplements
- O Specialized diet
- O Other _____

Does your child have a history of:

- O Vomiting
- O Constipation
- O Bad Breath
- O Diaper Rash
- O Eczema
- O Irritability
- O Respiratory Infections
- O Sinus Infections
- O Ear Infections
- O Pneumonia
- O Aspiration
- O Failure to Thrive
- O Bowel Obstruction
- O Short Bowel Syndrome
- O Gastroschesis
- O Dumping Syndrome
- O GI bleeding
- O Dehydration
- O EOE

Please Describe:

Has your child been exposed to antibiotics? YES/NO

- O Before birth
- O During Birth
- O Other:

Please provide details:

Please list vitamins and supplement (including probiotics) that your child is taking or has been given in the past

Please provide details:

Please complete if your child has had the procedures below:

PROCEDURE	PLACE	DATE	RESULT
Swallow Study (MBSS/ OPMS/FEES)			
Endoscopy			
Gastric Emptying			
Upper/Lower GI			
PH Probe			
Allergy Testing			
Other			

Does your child have food intolerances? YES/NO

Please describe

Does your child have:

- ○ Infrequent Bowel Movements
- ○ Frequent Bowel Movements
- ○ Loose Stools
- ○ Hard Stools
- ○ Foul Smelling Stools
- ○ Mucous in the Stool
- ○ Unusual Colored Stool

Has your child exhibited symptoms or been treated for GE Reflux? YES/NO

Please Describe:

Has your child been diagnosed or treated for lip and/or tongue tie? YES/NO

Please describe

Feeding History

1. TUBE FEEDING:

Does your child currently have a feeding tube? YES/NO
If yes, please check type of tube:

- O TPN
- O NG-Tube
- O G-J Tube
- O PEG Tube
- O G-Tube
- O J-Tube

Please describe your child's current tube feeding, including formula or recipe, schedule, volume, rate, delivery (bolus vs. pump):

Please ✔ your child's behavior during tube feedings:

- O Gagging
- O Nasal regurgitation
- O Screaming
- O Vomiting
- O Spitting up
- O Lethargy
- O Hiccuping
- O Retching
- O Back arching
- O Frequent burping
- O Sweating
- O Other: _____

If child does not have a feeding tube, did your child have a feeding tube in the past? YES/NO

If yes, type/ date removed/ reason for removal:

2. BREAST FEEDING:

Describe past or current difficulties with breastfeeding:

If currently breastfeeding, please describe schedule and length of feeding:

If child is no longer breast feeding, when and why did weaning occur?

3. *BOTTLE FEEDING:*

O Breast milk O Formula O Other: _____

Current formula: _____

Formula type: (Powder, Ready-to-feed, Concentrate) _____

Preparation (how many scoops powder, ounces of water): _____

List any previous formulas & describe tolerance: _____

_____

What brand/type/level of bottle and nipple is your child currently using? _____

_____

What bottles/nipples have you used in the past? _____

Describe past or current difficulties with bottle feeding:

If currently bottle feeding:

Please describe schedule, volume offered, volume typically accepted and length of feeding:

4. SOLIDS

At what age were solids first introduced? _____

What feeding utensils (spoons, forks, baby safe feeder, etc.) are you using for solid foods? _____

_____

Please check the types of food that your child accepts:

- ○ Infant cereal
- ○ Stage 1 commercial foods
- ○ Stage 2 commercial foods
- ○ Stage 3 commercial foods
- ○ Commercial Junior foods
- ○ Commercial diced toddler foods
- ○ Home made baby foods
- ○ Crunchy foods
- ○ Mashed table foods
- ○ Diced table foods
- ○ Whole table foods (Baby Led Weaning)
- ○ Other: _____

Please describe specific food likes/ dislikes:

Does your child have strong preference for foods with specific:

○ temperature ○ color ○ shape ○ brands ○ Other:

Please describe:

5. LIQUIDS

What types of liquids does your child accept in a cup? _____

Can your child drink from:

- ○ hard spout sip cup
- ○ soft spout sip cup
- ○ recessed lid cup
- ○ straw cup
- ○ open cup
- ○ other: _____

Please describe any difficulties with cup drinking:

Current Meal Pattern

Does your child exhibit any of the following behaviors during mealtime? Please indicate age when problems started.

- O Refuses all or most foods
- O Refuses all or most liquids
- O Liquids spill from mouth prior to swallowing
- O Eats only textures that are NOT age appropriate
- O Eats a limited variety of foods
- O Drinks a limited variety of liquids
- O Has problems with chewing
- O Has problems with swallowing
- O Overstuffs mouth
- O Eats too fast
- O Eats too slow
- O Refuses to swallow
- O Spits food out after chewing
- O Plays with food excessively
- O Throws food
- O Pushes food away
- O Turns head away from food
- O Refuses to open mouth for food
- O Vomits during meals
- O Refuses to self-feed
- O Is a messy eater
- O Coughs during meals
- O Chokes during meals
- O Vomits during meals
- O Sweats during meals
- O Cries or screams during meals
- O Wants “down” during mealtime
- O Refuses to sit at the table during family mealtime
- O Falls asleep during meals
- O Drinks from bottle or breast while asleep
- O Eats non-food items
- O Other: _____

Which meal is your child's best? _____

Which meal is your child’s worst? _____

How long does a 'typical' meal take? _____

Please list non-preferred foods/liquids: _____

Please indicate your child's typical meal schedule.

Number of meals/snacks per day: _____

Timing of meals/snacks: _____

Describe sequence in which food/liquids are offered:

- O Liquids first
- O Solids first
- O Liquids and solids at the same time

Do you think your child feels hunger? YES/NO

How does your child indicate hunger? _____

Feeding Practices

Does your child eat better for a particular feeder? YES/NO

If YES, Who is the preferred feeder? _____

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

- O Adults lap
- O Family Table/Chair
- O Car Seat
- O Toddler Table/Chair
- O High Chair
- O Specialized High Chair (Tripp Trapp, Height Right, etc.)
- O Modified Chair
- O Infant Seat
- O Tumble Form Chair
- O Sofa
- O Booster Chair
- O Crib/Bed
- O Wheel Chair
- O Rocking Chair
- O Roaming around
- O Other: _____

What techniques do you use with your child to get him/her to eat? Please ✓ all that apply.

- O Sleep (dream) feed
- O Coax
- O Praise
- O Threaten
- O Allow grazing throughout the day
- O Offer mini meals
- O Provide favorite foods frequently
- O Offer a different food when interest is lost
- O Change meal schedule to allow for hunger
- O Entertain
- O Ignore
- O Discipline
- O Time out
- O Force feed
- O Offer reward
- O Follow around house with food
- O Distract with TV, iPad, toys
- O Take to a distraction free room
- O Other: _____

Is there something we did not ask, that you think would be helpful for us to know?