**FEEDING INTAKE**

**Please fill out the information below and return either via fax, email, or in person at least 24 hours before your child's consultation.**

**Date Completed:**

**A. Identifying and Education Information**

**Patient name: _____** **Check one: ____Male ____Female**

**DOB:** **Age:** **Weight:** **Height:**

Referring physician:

Primary Diagnosis:

Reason for referral:

Home address:

City, State, Zip:

Parent/Guardian Name(s):

Email:

Home phone: Cell phone:

Who is filling out this questionnaire? Relationship to child:

How did you hear about EBS feeding program?

Languages spoken at home:

Is your child enrolled in any type of childcare facility? Yes No

Name of School/Facility: Date Enrolled:

Hours per week: Current Grade:

Describe any special assistance or accommodations provided in the educational setting:

Has your child ever had a Feeding/ Speech and Language/ Occupational/ Physical/ Behavioral/ Psychological evaluation? Yes No

If so, what kind of evaluation?

When? Would you mind sharing the results? Yes No

Does your child receive therapy at this time? x/week

Where does your child receive these services?

Has your child received therapy services in the past? Yes No

Type and Date services ended:

**B. Pertinent past and current medical information**

**Prenatal/birth history**

Length of pregnancy (weeks):

Were there any complications during pregnancy or delivery?

If yes, please explain:

_____

**Hospitalization/surgical history**

Date(s):

Reason (s) for hospitalization:

**Known precautions/allergies**

Medical allergies: Latex ☐ Other:

Food allergies: Dairy ☐ Gluten ☐ Nuts ☐ Soy ☐ Other:

Does your child require an EpiPen for any allergies? Yes ☐ No ☐

Food intolerances: Dairy ☐ Gluten ☐ Nuts ☐ Soy ☐ Other:

Comments:

_____

_____

____

**Current Medications:** Not applicable (Skip to Next Section)

**Medication 1:** How long been taking?_____Prescribed for:
**Medication 2:** How long been taking? _____ Prescribed for:
**Medication 3:** How long been taking?_____ Prescribed for:

**Additional Medications:**

_____

_____

____

**Neurologic History/Current Concerns** Not applicable (Skip to Next Section)

**HISTORY** of neurologic deficits? Yes □ No □

If yes, please check:

Abnormal muscular tone (high) ☐ Abnormal muscular tone (low) ☐ Anoxia ☐ Ataxia ☐
Brain tumor ☐ Hydrocephalus ☐ Microcephaly ☐ Paralysis ☐ Seizures☐ Stroke ☐
TIAs ☐ Tremor ☐ Other:

If any box checked, please explain:

**CURRENT** neurologic status**:** No problems ☐

Current issue(s) ☐ Regular follow-up with neurologist ☐

If current issues please explain:

_____

_____

**Cardiac History/Current Concerns** ☐ Not applicable (Skip to Next Section)

**HISTORY** of heart problems? Yes ☐ No ☐

If yes, please indicate the specific heart problem or suspected problem:

Please check if any of the following **have** occurred:

Surgery ☐ Episodes of cyanosis ☐ Altered activity level ☐ Intolerance of specific positions secondary to cardiac condition ☐

Known complications from cardiac condition: CVAs ☐ TIAs ☐ Vocal fold paralysis ☐ Other ☐

If any box checked, please explain:

_____

_____

____

**CURRENT** cardiac status**:** No problems ☐ Current issue(s) ☐ Regular follow-up with cardiologist (physician name)

If current issues please explain:

_____

_____

**Respiratory History/Current Respiratory Concerns** ☐ Not applicable (Skip to Next Section)

**HISTORY** of respiratory problems: (check all that apply)

Apnea (Obstructive) ☐ Apnea (Central) ☐ Asthma ☐ Bronchitis/bronchiolitis☐ Bronchopulmonary Dysplasia (BPD) ☐ Malacia (broncho) ☐ Malacia (laryngo) ☐

Malacia (tracheo) ☐ Nasal/Chest Congestion ☐ Pneumonia ☐ Tracheal stenosis ☐

Wheezing ☐ Other:

If pneumonia, how many times? _____

Was it ever classified as aspiration pneumonia? Yes ☐ No ☐

If yes, please explain:

_____

Approximate number of colds per year: normal □ above average □

Approximate number of upper respiratory infections per year: _____

Tracheostomy tube? Yes ☐ No ☐

If yes (history of tracheostomy tube), please answer the following: Reason for trach AND length of time child had the trach:

Complications related to the trach (granuloma tissue build-up, etc.): Yes ☐ No ☐

If yes, please explain:

_____

_____

**Gastrointestinal History/Current Gastrointestinal (GI) Concerns** ☐ Not applicable (Skip to Next Section)

**HISTORY** of GI deficits? Yes ☐ No ☐

If yes, check all that apply: Altered peristalsis ☐ Bowel obstruction ☐ Crohn's Disease ☐ Chronic diarrhea ☐ Constipation ☐ Dehydration ☐ Diabetes ☐ Esophagitis ☐

(Eosinophilic) Esophagitis (general) ☐ Failure to thrive ☐ GI bleeding☐ Hypoglycemia ☐ Reflux ☐

Slow gastric emptying ☐ Short bowel syndrome ☐ Vomiting ☐ Other:

If yes, please provide additional notes:

**HISTORY** of GI surgery: Yes No

If yes, check all that apply: Colostomy ☐ Fundoplication ☐ Pylorotomy ☐ Short gut ☐

**Did** your child ever receive any alternative feeds? Yes ☐ No ☐

If yes, please select (all that apply): NG-tube ☐ G-tube ☐ J-tube ☐ PEG tube ☐ PEJ tube ☐

TPN ☐ Other:

Type of feeding received: Bolus ☐ Continuous drip ☐ Combination ☐ Other ☐

Has your child ever had any of the following tests completed?

MBS ☐ FEES study ☐ Upper GI ☐ Barium Swallow ☐ pH probe ☐ Sialogram ☐ Other:

If so, please indicate the dates and results of tests. If multiple tests completed only provide the most recent on the lines below:

_____

_____

_____

**Early oral feeding trials:** Chronology of formulas (if child less than 3, please indicate all formulas trialed/utilized) and any comments on poor tolerance:

_____

_____

_____

**CURRENT** GI status (check all that apply): No problems ☐ Current issues ☐ Regular follow-up with gastroenterology ☐ (physician name)

Regular follow-up with pediatrician for GI issues: Yes ☐ No ☐

Do you or your doctor have concerns about recent weight gain or weight loss: Yes ☐ No ☐

If yes, please explain:

_____

_____

_____

Has your child ever had a nutritional consult? Yes ☐ No ☐

If yes, please provide the name of consultant and date last visited with any pertinent comments:

_____

_____

_____

Has your child ever had blood tested to determine nutritional deficits? Yes ☐ No ☐

If yes, please provide date of most recent testing and results:

_____

_____

_____

If your child currently has reflux, have you ever noted coughing or a "gurgly" voice after the episode? Yes ☐ No ☐

If your child currently suffers from recurrent vomiting, approximately how many times daily do they vomit?

_____

_____

_____

Is your child currently receiving tube feeds? Yes □ No □

If yes, what Type? NG-tube □ PEG tube □ PEJ tube □ G-tube □ J-tube □ Other: _____

Current rate: _____

Current schedule: _____

Additional current GI issues, please explain:

_____

_____

_____

**Craniofacial history/Current Craniofacial Concerns** Not applicable (Skip to Next Section)

**HISTORY:** Has your child ever had any known defects of the lip and/or palate? Yes ☐ No ☐

If yes, please explain:

_____

_____

_____

Does your child have a diagnosed syndrome, association, or sequence? Yes ☐ No ☐

If yes, please explain:

_____

_____

_____

**History** of sinus infections? Yes □ No □

**History** of resonance pattern deficits? Yes □ No □

**History** of surgical repair(s) Yes □ No □

If yes or want to add additional comments, please provide below:

_____

_____

_____

**CURRENT** craniofacial status (check all that apply): No problems ☐ Current issues ☐

Regular follow-up with (check all that apply): genetics □ plastic surgery □ ENT □

Do you ever notice food or liquid coming out of the nose? Yes ☐ No ☐

If yes, please select:

Frequency? Every meal ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely ☐ Other:

Type of consistency? Thin Liquids ☐ Thick liquids ☐ Puree ☐ Solids ☐ With straw use? Yes ☐ No ☐

Position(s) of the child? (Seated, laying, etc.)

_____

If additional current problems, please explain:

_____

**Dental History/Current Dental Concerns**

**HISTORY** Has your child ever been to the dentist? Yes ☐ No ☐

Most recent dental visit and results:

_____

_____

_____

Has your child ever had dental surgery or any unusual dental findings? Yes ☐ No ☐

If yes, please explain:

_____

_____

_____

**CURRENT dental status (check all that apply):** No problems ☐ Current issues ☐

Regular follow-up with dentist/orthodontist □

Does your child have normal dentition (number/placement of the teeth)? Yes ☐ No ☐

If yes to either of the previous questions, please explain:

_____

_____

_____

Are your child's teeth currently brushed daily? No ☐ Yes ☐

By whom? Child ☐ Parent/Caregiver ☐ Other:

Reaction to tooth brushing: Enjoys ☐ Resists ☐ Other:

If selected "resists" or "other," please explain:

_____

_____

_____

Before leaving medical history, are any additional medical specialists involved with child (check all that apply): Dermatology ☐ Psychiatry ☐ Psychology ☐ Other

If yes, please explain:

_____

_____

_____

## C. Current Nutritional Status/Feeding History/Responses to Food/Current Skills

a. Current oral feeds volume: Exclusive (all nutrition received by mouth) ☐

Partial supplementation with tube ☐ "Tastes" (for pleasure/stimulation/exposure) ☐ N/A ☐

b. For LIQUIDS, please answer the following questions:

Does your child require the liquids to be thickened? Yes □ No □

If yes, please indicate degree liquids are thickened and recipe used:

_____

If yes, please indicate the length of time your child has been on thickened liquids:

_____

Does your child CURRENTLY take any liquids orally that do not have to be thickened? Yes ☐ No ☐

If yes, please answer the following questions:

| **First took/used** | **Current Use** |
|---|---|
| Breast N/A Age: | |
| | Takes/uses now? Yes No If no, age stopped |
| Bottle N/A Age: | |
| | Takes/uses now? Yes No If no, age stopped |
| No-spill cup N/A Age: | |
| | Takes/uses now? Yes No If no, age stopped |
| Straw N/A Age: | |
| | Takes/uses now? Yes No If no, age stopped |
| Open cup N/A Age: | |
| | Takes/uses now? Yes No If no, age stopped |
| Other N/A Age: | |
| | Takes/uses now? Yes No Comment: |

How many ounces of fluid does your child consume daily? _____ Does your child ever cough or choke with liquids? Yes ☐ No ☐

Does your child ever sound gurgly while drinking or immediately after? Yes ☐ No ☐

If yes, please comment:

_____

_____

_____

Please select the types of liquid that is regularly consumed:

Water ☐ Breast milk ☐ Formula ☐ Milk ☐ Juice ☐ Soda ☐ Yogurt drinks ☐

Other:

_____

Comment on any preferences of a specific brand of nipple or cup:

_____

_____

_____

**For FOODS, please answer the following questions:**

Does your child **CURRENTLY** take any foods orally? Yes ☐ No ☐

If no, and never did, please go to section on smell and taste; Otherwise please answer the following questions.

| **First took/used** | **Current Use** |
|---|---|
| Spoon (by caregiver) N/A Age: | Now? Yes ☐ No ☐<br>Comment: |
| Fingers (by caregiver) N/A Age: | Now? Yes ☐ No ☐<br>Comment: |
| Utensils (self) N/A Age: | Now? Yes ☐ No ☐<br>Comment: |
| Fingers (self) N/A Age: | Now? Yes ☐ No ☐<br>Comment: |
| Other N/A Age: | Now? Yes ☐ No ☐<br>Comment: |

How many ounces of food (approximately) does your child orally consume daily?

_____

Does your child ever cough or choke with food? Yes ☐ No ☐

Does your child ever sound" gurgly" while eating or immediately after? Yes ☐ No ☐

If yes, please comment:

_____

Please select the types of food consistency (select all that apply) that is regularly consumed:

Thin puree (e.g. baby food apricots) ☐ Puree (e.g. pudding) ☐ Dissolvable solids (e.g. puffs) ☐

Soft solids (e.g. cheese, raisins) ☐ Hard solids (e.g. cookies, dry cereal) ☐

Multiple consistencies (e.g. dry cereal with milk) ☐

Difficult to chew foods (e.g. meat, raw vegetables) ☐ Other ☐

Does your child require any specialized feeding equipment? Yes No

If yes please comment:

_____

_____

_____

Please select the **variety** of foods that your child will eat:

Fruits: None 1-2 3-4 More than 5;

Comment:_____

Vegetables None 1-2 3-4 More than 5;

Comment: _____

Grains None 1-2 3-4 More than 5;

Comment:_____

Dairy None 1-2 3-4 More than 5;

Comment:_____

Meats None 1-2 3-4 More than 5;

Comment:_____

Do you or your doctor have any concerns regarding the variety of foods that your child will eat?

Yes ☐ No ☐

If yes, please comment:

_____

Would you consider your child to be a "picky" eater? Yes ☐ No ☐

Does your child prefer foods that are: Room temperature ☐ Hot ☐ Cold ☐?

**Smell and Taste**

| | | | | | | |
|---|---|---|---|---|---|---|
| Smell: | WFL | Unknown | Heightened | Diminished | | |
| Taste: | WFL | Unknown | Heightened | Diminished | | |
| Preference: | Sweet | Salty | Bitter | Sour | Strong flavors | Other: |

---

Would you say that your child gags easily with different foods? Yes ☐ No ☐

If yes, please explain:

_____

Do you prepare special meals? Yes ☐ No ☐

If yes, how many meals per day? _____

Do you feel you to have play games to distract your child to get them to eat? Yes ☐ No ☐

If yes, how frequently do you have to use this distraction? _____

Do you feel you must reward the child to get them to eat? (i. e. airplane game, clapping, bubbles)

Yes □ No □

If yes, how frequently are the rewards used? _____

Do you notice a difference in how much your child eats or how long they stay engaged based on who may be feeding them or different environments? Yes ☐ No ☐

If yes, please explain:

_____

_____

_____

Does your child display any behavior problems during mealtimes? Yes □ No □

If yes, please specify:

□ Throws Food

□ Spits Food

□ Cries, screams

□ takes food from others

□ overeats

□ leaves the table before finished

Does your child have any other behavioral issues outside of feeding?

If so, please describe:

_____

_____

_____