FEEDING INTAKE

Please fill out **ALL** of 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? Yes ☐ No ☐ _____ x/week

Where does your child receive these services? _____

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

Type of services and date services ended: _____

B. Pertinent past and current medical information

Please fill out this section to the best of your ability, with as much detail as possible.

Prenatal/Birth History

Length of pregnancy (weeks): _____

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

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: _____

Does your child have any other dietary restrictions? _____

Comments:

_____

_____

Current Medications ☐ Not applicable (Skip to Next Section)

Medication 1: _____ Dosage: _____

How long been taking? _____ Prescribed for: _____

Medication 2: _____ Dosage: _____

How long been taking? _____ Prescribed for: _____

Medication 3: _____ Dosage: _____

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 explain 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:

_____
_____
_____

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 applicable, when did the reflux resolve? _____

Who said it was resolved? _____

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: _____

Please explain any additional current GI issues:

_____

_____

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

Does your child have any past or current craniofacial concerns? Yes ☐ No ☐

If yes, 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 ☐

Does your child have a regular follow-up with dentist/orthodontist? Yes ☐ No ☐

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 ☐

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

_____

_____

_____

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 (nectar, honey, 1-slightly thick, 2-mildly thick, etc.):

_____

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

_____

First Took/Used (Best Guess)	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:

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

_____

_____

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: _____

For FOODS, please answer the following questions:

First Took/Used (Best Guess)	Current Use
Spoon (by caregiver) N/A Age:	Now? Yes ☐ No ☐ Comment:
Fingers (by caregiver) N/A Age:	Now? Yes ☐ No ☐ Comment:
Utensils (self) N/A Age:	Now? Yes ☐ No ☐ Comment:
Fingers (self) N/A Age:	Now? Yes ☐ No ☐ Comment:
Other N/A Age:	Now? Yes ☐ No ☐ 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 circle 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 ☐ No Preference ☐

Smell and Taste (please circle)

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? _____

Where does the child sit during mealtimes? _____

What type of chair do they sit in? _____

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

□ Verbally refuses

□ Pushes food away

□ Sneaks food

□ Leaves the table before finished

Who is typically present during meals? _____

Is there a time of day when meals are less challenging? _____

Does your child have any other behavioral issues outside of feeding? Yes ☐ No ☐

If so, please describe:

_____
_____
_____

Strategies currently used for challenging behaviors **AFTER** they occur (please indicate what has been successful/unsuccessful):

_____
_____

Strategies currently used for challenging behaviors **BEFORE** they occur (please indicate what has been successful/unsuccessful):

_____
_____

Does your child currently have a Positive Behavior Support Plan or Behavior Intervention Plan? If so, would you mind sharing it with us?

_____

Child's preferred items/activities: _____