2148 Awapuhi St. Hilo, HI 96720
Office: (808) 365-8128
Fax: (808) 961-6383

Feeding Intake Form

Please email the completed form to syd@walaautherapy.com

1. General Information

Child's Name: _____ Date of Birth:_____ Age: _____

Parent/legal guardian(s) names: _____

Child lives with both parents? Yes ☐ No ☐ if no, whom does the child live? _____

Home Address (Street, Town, State): _____

Mailing Address (P.O. Box, street, etc.): _____

Phone number: ( ) _____ - _____ Best time to contact *(circle)*: morning afternoon evening

Email address: _____ Primary Medical Doctor: _____

Please describe below present concerns/problems regarding your child:

_____

_____

_____

_____

Does your child have a diagnosis? Yes ☐ No ☐ If yes, diagnosis: _____

Has your child been seen previously by other therapists (Physical therapist, occupational, speech-language pathologist)?
Circle one. Yes No

If yes, where was your child seen? _____

What type of therapy services did your child receive (physical, occupation, speech/language)?

_____

How long did he/she receive therapy services? _____

How well is your child understood? (e.g. what percentage of the time?)

Parents: _____ Siblings: _____ Grandparents: _____

Other children: _____ Extended family: _____Unfamiliar adults _____

2. Prenatal/Birth History

Was your child born Full-term? Yes ☐ No ☐ If no, how many weeks? _____

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

If yes, please explain: _____

Were there any medical problems detected at birth? Yes ☐ No ☐

If yes, please describe: _____

Birth weight: _____. Delivery: Vaginal _____ Cesarean: _____ N.I.C.U.: Yes ☐ No ☐

3. Medical History

Please check if your child had any of the following *(and if so, at what age)*

Seizures_____ High fevers_____ Chicken pox _____ Whooping cough_____ Tonsillitis_____

Meningitis_____Pneumonia_____ Encephalitis_____ Chronic colds_____ Asthma_____

Heart problems_____ Ear infections: _____Other: _____

Please explain any checked items here: _____

_____

Has your child had any serious illnesses, injuries, surgeries, or hospitalization? Yes ☐ No ☐

If yes, please explain: _____

Are immunizations current? Yes ☐ No ☐

Does your child currently take any medications? Yes ☐ No ☐

If yes, please describe name, dosage, frequency, and if any side effects.

_____

Does your child have any allergies: Yes ☐ No ☐

If yes, please describe: _____

Vision problems: Yes ☐ No ☐ Hearing difficulties: Yes ☐ No ☐

Has your child's hearing been tested by an Audiologist? Yes ☐ No ☐

4. Developmental History

Please list the ages your child achieved the following developmental milestones	
Skill	**Age Achieved**
Sat Independently	
Crawled	
Walked Independently	
Babbled	
Said first words	
Combined two words	
Produced sentences	

5. Feeding History

Please describe all that apply	
History of Oxygen and Ventilation Support following birth	
History of NG tube feeding	
History of Traceostomy	
History of G-tube feeding	
HIstory of poor weight gain	
HIstory of failure to thrive	
History of feeding difficulties as an infant (e.g. colic, reflux, difficulty nippling, etc.)	
Chest X-ray	
Videofluroscopy	
Endoscopy	
Allergy studies	
Upper GI series	

6. Is your child currently being treated for reflux? ☐ Yes ☐ No

7. Has your child ever had a problem with ☐ vomiting ☐ gagging ☐ choking

If yes, when did the problem start?_____

How and when was the problem resolved? _____

When does vomiting occur?
- ☐ During feeding
- ☐ After feeding
- ☐ unrelated to feeding
- ☐ when upset

How often does vomiting occur?
- ____ times per day
- ____ times per week
- ____ times per month
- ____ occasionally

8. Are stools usually: ☐ watery ☐ formed ☐ runny ☐ pasty ☐ constipated ☐ foul smell

Has your child ever had a problem with constipation? ☐ Yes ☐ No

9. Please indicate where your child regularly experiences the following symptoms/behaviors:

- ☐ Spits up_____
- ☐ Wet burps_____
- ☐ Frequent sore throat _____
- ☐ Arching _____
- ☐ Painful swallow: _____
- ☐ Gagging _____
- ☐ Nasal regurgitation _____
- ☐ Persistent, non-seasonal cough_____
- ☐ Wet, “gurgly” voice sounds _____
- ☐ Frequent chest colds _____
- ☐ Hives _____
- ☐ Eczema _____
- ☐ Sneezing, running nose_____
- ☐ Spits/up/re-swallows_____
- ☐ Wet pillow after sleeping _____
- ☐ hoarse voice or cry _____
- ☐ colicky/fussy behavior _____
- ☐ abdominal pain/cramping _____
- ☐ choking _____
- ☐ Stops eating after small amounts of food
- ☐ Noisy breathing _____
- ☐ Wheezing _____
- ☐ Frequent ear infections _____
- ☐ Rash _____
- ☐ Itching _____
- ☐ Vomiting _____

10. Mealtime Routines and Behaviors

I. Describe your child‘s daily schedule for mealtimes and snacks:

_____

_____

II. How long do mealtimes usually take? _____

III. Please list all the locations where your child regularly eats and note who is present.

_____

_____

IV. Does your child eat better in some locations than in others?

_____

_____

V. Does your child feed himself? *Check all that apply.*

☐ holds bottle (*6+ mos*) ☐ uses cup ☐ eats finger foods (*14-16 mos*)
☐ uses spoon (*14-30 mos*) ☐ uses fork (*14-36 mos*)

Comments: _____

11. Seating and Positioning

☐ Parent's arms:
☐ High chair
☐ Booster seat
☐ Child table and chair
☐ adult table and chair
☐ does not sit for meals/snacks

12. Does your child have any of the following problems? *Please include estimated date of onset:*

Problem	Date of onset
Food refusal *(refusing all or most foods)*	
Food selectivity by texture *(eating only textures that are not developmentally appropriate)*	
Food selectivity by type *(eating only a narrow variety of foods)*	
Dysphagia *(problem with swallowing, aspiration)*	
Abnormal preferences *(refuses food if not a certain temperature, eats only certain brands, must have a certain cup or special silverware to eat)*	

Does your child show any of the following behaviors during meal or snack time?

☐ Reluctant to touch certain textures of food
☐ Spitting out certain textures
☐ Cough or gag with food in mouth
☐ Pockets food in mouth
☐ Can't locate or loses food in mouth
☐ Swallow food whole or barely chewed
☐ Overstuff mouth
☐ Grinds teeth
☐ Turn head away
☐ Looking away from foods
☐ Distress with sight of foods on table
☐ Distress with sight of foods on plate
☐ Cough or gag with sight of food
☐ Covers ears during meal
☐ Distracted and inattentive during meals
☐ Eye blinking or watering
☐ Covering nose
☐ Cough or gag to smells

Do you have any concerns about your child's behavior during meals and snacks? Please describe:

_____

What do you do when your child is demonstrating their behavior during meal time?

_____

What feeding techniques do you use with your child to get them to eat?

- ☐ coax
- ☐ praise
- ☐ distract with toys
- ☐ offer reward
- ☐ time out
- ☐ limit food
- ☐ mini-meals
- ☐ use electronics
- ☐ threaten
- ☐ force feed
- ☐ change foods offered
- ☐ ignore
- ☐ change schedule

13. Overall description of Appetite

☐ Good ☐ Fair ☐ Poor ☐ Varies meal to meal ☐ Varies day to day

14. List your child's favorite foods *(include brand name if that makes a difference to them)*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

15. List your child's favorite beverages *(include brand name if this makes a difference to them)*

1. _____
2. _____
3. _____

16. List any food you would like to see your child eat

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

17. Food Texture - Please check the textures of food that your child will/can eat

- ☐ *puree (smooth, not too thick with no lump, e.g. pudding, applesauce, baby foods)*
- ☐ *soft mashed (soft foods with uniform texture, e.g. mashed potato or squash)*
- ☐ *dissolvable solids (dry solids with uniform texture that melts in mouth, e.g. cheese puff)*
- ☐ *soft cubes (soft, bite-sized food that holds shape, e.g. cubed banana or avocado)*
- ☐ *soft mechanical (soft foods that don't require extensive chewing, e.g. scrambled eggs, sliced deli meat)*
- ☐ *mixed textures (soft foods with more than one texture, e.g. Mac&cheese, soft grilled cheese)*
- ☐ *hard mechanical/crunchy (hard exterior that requires some chewing, e.g. nuts, frito corn chips)*
- ☐ *chewy solids (e.g. dried fruits, beef or fish jerky)*
- ☐ *hard chewy solids (e.g. raw vegetables such as carrots)*

18. Taste Preferences

☐ salty ☐ sweet ☐ spicy ☐ bland ☐ other:_____

19. Temperature Preferences

☐ hot ☐ cold ☐ cool ☐ warm ☐ other:_____

20. Are there any foods that your child used to eat that they now reject? *Please list:*

_____

21. Does your child appear to crave certain foods?

_____

22. Food Checklist

Please check the boxes for food that your child will currently eat. Please note if your child will only eat a certain type or brand, or only if prepared in a certain way.

Chips/snacks:

☐ crackers
☐ granola bars
☐ potato chips
☐ pretzels
☐ other: _____
☐ cheese or veggie puffs
☐ popcorn
☐ goldfish

Breads/cereals/grains:

☐ hot cereal
☐ pancakes
☐ toast
☐ cake
☐ pizza crust
☐ garlic bread
☐ bread stick
☐ dry cereal (with milk?____)
☐ waffles
☐ rolls/buns
☐ rice
☐ biscuit/cookie
☐ French toast
☐ muffins
☐ pasta (any sauce_____)
☐ tortilla
☐ bread, untested
☐ other:_____
☐ toppings (if any, on toast, pancakes, etc)_____

Potato products:

☐ French fries
☐ baked potatoes
☐ baked sweet potato
☐ tator tots
☐ potato wedges
☐ mashed potatoes
☐ hash browns
☐ other:_____-

Cheese/dairy

- [ ] milk
- [ ] cottage cheese
- [ ] soft cheese
- [ ] medium-hard cheese
- [ ] yogurt
- [ ] cream cheese
- [ ] breakfast drinks
- [ ] ice cream

other:_____

Fruit *(please indicate if raw, dried, and/canned)*

- [ ] apple
- [ ] cherries
- [ ] pear
- [ ] banana
- [ ] pineapple
- [ ] lemon
- [ ] other: _____
- [ ] fruit juice? _____
- [ ] fruit inside breakfast bars?_____
- [ ] watermelon
- [ ] grapes
- [ ] papaya
- [ ] lime
- [ ] melon
- [ ] blueberries
- [ ] raisins
- [ ] tangerine
- [ ] orange
- [ ] kiwi
- [ ] strawberry
- [ ] fruit cocktail
- [ ] fruit mixed with yogurt? _____
- [ ] fruit topping or jams? _____
- [ ] fruit filling in pies? _____

Vegetables *(please note of raw, canned, cooked, or baby food)*

- [ ] green beans
- [ ] squash
- [ ] carrots
- [ ] sweet potatoes
- [ ] bell pepper
- [ ] peas
- [ ] other:_____
- [ ] broccoli
- [ ] cucumber
- [ ] lettuce
- [ ] tomatoes
- [ ] cauliflower
- [ ] zucchini
- [ ] cabbage
- [ ] asparagus
- [ ] onion
- [ ] corn
- [ ] spinach
- [ ] mushroom

Protein

- [ ] baked chicken
- [ ] chicken nuggets
- [ ] baked fish
- [ ] fisk sticks
- [ ] steak
- [ ] deli meat
- [ ] sausage
- [ ] canned meat
- [ ] scrambled egg
- [ ] hamburger
- [ ] roast beef
- [ ] bacon
- [ ] meatballs
- [ ] ham
- [ ] omelet
- [ ] boiled egg
- [ ] tuna
- [ ] hot dog
- [ ] tofu
- [ ] turkey

___ other:_____

___ nut or nut butters:_____

___ soy products:_____

___ meat substitutes:_____

Condiments

☐ ketchup
☐ mustard
☐ mayonnaise
☐ butter/margarine
☐ jelly/jam
☐ BBQ sauce
☐ salad dressing
☐ other sauces/dips/toppings:_____

Drinking

Does your child drink from: ☐ open cup ☐ sippie cup ☐ straw ☐ bottle

Does your child require a liquid supplement: ☐ Yes ☐ No

If yes, which one? _____ *How much/day?*_____

What kind of milk does your child consume?

☐ Whole
☐ 2%
☐ 1%
☐ skim
☐ soy
☐ rice
☐ oat

☐ other:_____

How many ounces of milk doe your child consume in a day? _____

How much juice does your child consume in a day? _____

Does your child drink water? ☐ Yes ☐ No

*if yes, how many ounces a day?*_____

Oral Motor

Do you have concerns about oral motor delays? (*Drooling, difficulty chewing*) ☐ Yes ☐ No

If yes, please check all that has been observed below.

☐ poor tongue control
☐ coughing/gagging
☐ poor lip control
☐ drooling
☐ problems with biting
☐ poor sucking
☐ swallowing problems
☐ lack of chewing
☐ hypersensitive
☐ teeth grinding

☐ Other:_____

Goals

What are your goals? *Check all that apply.*

☐ Increase the volume of food my child eats
☐ Increase the variety of food my child eats
☐ Improve oral motor skills
☐ Increase weight gain
☐ Decrease gagging/vomiting during meals
☐ Improve cup drinking
☐ Improve mealtime behaviors
☐ decrease tube dependency
☐ Other:_____

Is there anything else you would like me to know about your child?

_____

_____

_____

_____

MAHALO