Infant Feeding Intake Form
(0-4 months)

Welcome to Carolinas Rehabilitation outpatient clinic. We look forward to working with your family, and thank you for choosing Carolinas Rehabilitation. To help us assess your baby's feeding skills and challenges, please complete the case history form below and bring the following items to your feeding evaluation:

- ***Your baby's preferred and challenging feeding utensils*** (ex. bottle, nipples, pacifier)
- ***Your baby's preferred and challenging liquid (***formula, breast milk)

1. FEEDING CONCERNS & HISTORY

Why are you requesting a feeding evaluation? _____

What do you want your baby to accomplish in therapy? _____

Briefly describe your baby's behavior during mealtime. (burping, hiccups, crying, squirming, etc)

_____

Please list your baby's current diet. (ex. formula name, breast milk) _____

Please list the current bottle and nipple your baby is using. _____

How many times a day is your baby fed? _____

Is your baby on a feeding schedule? If so, please describe._____

Approximately how much liquid does your baby drink during each feeding? _____

How long does each feeding take? _____

How is your baby positioned when eating? _____
(ex. held by caregiver, swaddled in a blanket, side lying, upright, facing the caregiver, etc)

Does your baby eat more/less when he/she is fed by someone else or in a different location? If so, please describe (ex. at daycare, with baby-sitter, with other family members, etc)

_____

What have you tried to do to help your baby with his/her feeding problem?

_____

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2. DEVELOPMENTAL/MEDICAL HISTORY

Please check **YES-NO-NA** with comments as needed:

	YES	NO	N/A	Comments
Any prenatal complications				
Premature birth (born at 36 weeks or earlier)				
Hospitalizations since birth				
Difficulties breast or bottle feeding				
Respiratory difficulties at birth				
Tube feedings				
History of constipation, reflux (any stomach issues)				
Trialed various formulas (if yes, please list)				
Require thickened liquids				
Low birth weight				
Minimal weight gain				
Currently taking medication				
History of aspiration				
Therapies received or recommended since birth				
Previous feeding/ swallowing evaluations				
Food allergies (if yes, please list)				
Tolerates touch to face and mouth (touching face, mouthing objects, pacifier)				
Family history of feeding problems				

Therapist _____ Date_____

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