Pediatric Feeding Intake Form
(4 months and older)

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 child's feeding skills and challenges, please complete the case history form below and bring the following items to your feeding evaluation:

- ***Child's favorite/preferred feeding utensils***
  (ex. bottle, nipples, pacifier, sippy cup, spoon, bowl, etc)
- ***1-2 of your child's favorite food items and liquid*** (snack or small portion)
- ***1-2 food items that are challenging or undesirable for your child***
- ***½-1oz of breast milk/formula*** (if applicable)

1. FEEDING CONCERNS & HISTORY

Why are you requesting a feeding evaluation? _____

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

When was your child weaned from the breast/bottle? _____

When did your child start to eat solid foods? _____

When did your child start to feed him/herself? _____

If your child does not feed him/herself, who feeds him/her? _____

Where does your child eat? _____

Are there any other activities going on during meal time? (ex. TV, toys) _____

How is your child positioned when eating? (ex. sitting in high chair, on the floor, standing)

_____

Who else is present for meals? _____

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FEEDING CONCERNS & HISTORY continued

Does your child eat more/ less, or different types of foods 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)

_____

How long does each meal take? _____

How many times a day does your child eat? _____

Approximately how much liquid does your child drink at each meal? _____

Does your child drink juice? If *yes*, how much in a day, and when is it offered? _____

Approximately how much food does your child eat at each meal? _____

How would you describe your child's appetite? (ex. strong, variable, poor) _____

Please list preferred/easy foods your child eats: _____

Please list non-preferred/difficult foods: _____

Does your child exhibit any of the following behaviors when eating: (please check)

_____crying
_____ gagging
_____ vomiting
_____ coughing
_____other (please list)_____

_____ spitting food out of his/her mouth
_____ regurgitating food
_____ holding food in his/her mouth
_____ getting down from the table during the meal

What consistency of foods does your child eat? (please check)

regular liquids _____
thickened liquids _____
baby cereal _____
stage 1 baby foods (thin, smooth) _____
stage 2 baby foods (thick, smooth) _____
soft mashed table food (lumpy) _____
finger foods _____
table food _____

Current feeding utensils used: (please check)

bottle/nipple _____ list type _____
breast _____
cup _____
sippy cup _____
straw _____
finger feeding _____
spoon _____
fork _____

What have you tried to do to help your child 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
Prenatal complications				
Premature birth (born at 36 weeks or earlier)				
Hospitalizations since birth				
Difficulties breast / bottle feeding				
Respiratory difficulties at birth				
Tube feedings				
History of constipation, reflux (any stomach issues)				
Trialed various formulas				
Low birth weight				
Minimal weight gain				
Current medications				
History of aspiration				
Difficulty transitioning to solids (baby food/soft table food)				
Accepts liquids from cup (sippy/straw/open) by 18 months				
Thickened liquids required or recommended				
Therapies received or recommended since birth				
Previous feeding/ swallowing evaluations				
Sitting up by 7 months				
Crawling by 12months				
Walking by 18 months				
Food allergies (if yes, please list)				
Dental visits (first visit recommended by 3 years)				
Tolerates touch to face and mouth (brushing teeth, washing face, mouthing toys)				
Family history of feeding problems				

Therapist Signature: _____ Date: _____

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Pediatric Feeding Journal

Please observe your child's oral intake throughout the next 1-3 days. Please record the type of food/ drink given, the amount consumed, the time the food/ drink is presented and any responses or problem behaviors you observe (ex. coughing, gagging, spit out, shut mouth, refused):

	Day #1	Day #2	Day #3
Breakfast Time:			
AM Snack Time:			
Lunch Time:			
PM Snack Time:			
Dinner Time:			
After Dinner Snack Time:			
Additional Snacks/Meals Time:			

Thank you for taking the time to complete your child's history form and feeding journal. We look forward to working with your family and thank you for choosing Carolinas Rehabilitation to help meet your child's needs.

Therapist Signature: _____ Date: _____

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