SANTA FE therapy ASSOCIATES

Speech-Language Therapy • Occupational Therapy • Physical Therapy • Orofacial Myofunctional Therapy
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Patient name:	DOB:	Today's Date:

Why is your child being seen for a feeding evaluation?

Birth History

Birth Weight: _____ **Most recent weight:_____**

Was your child born at full term? How many weeks? _____

Please list any problems during pregnancy:

Please list any problems immediately after birth:

Feeding History

Breast-fed?_____ Bottle-fed? _____ Other? _____

Any problems with any of these? (weak suck, slow to feed, coughing, crying, etc.)

When did your child start to eat solid foods? _____
Were there problems with this? _____
When was your child weaned? _____
Does your child drink juice? _____ How much in a day? _____
Does your child drink milk/juice before a meal? _____

Does your child exhibit any of the following during meals:
_____ crying _____ gagging _____ vomiting _____spitting food out

_____ holding food in mouth _____regurgitating food _____ getting down from the table

_____ stiffening _____ loosing latch frequently _____ coughing/sputtering

How many times a day does your child eat? _____

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

How is your child positioned when eating? (sitting in highchair, sitting on the floor, come and go, etc.)

_____

Does your child eat more/less, same/ different foods when they are at day care, baby sitter, other? (Circle and describe below).

Does your child receive supplemental (tube) feeding? _____

Amount: _____ **Rate:** _____ **How often?** _____

NG: ☐
PEG: ☐
PEJ: ☐

Bolus via syringe: ☐
Continuous via pump: ☐

What consistencies does your child eat?

Regular liquid: ☐ **Stage 1 baby foods (smooth):** ☐ **Mashed table food** ☐
Thickened liquid: ☐ **Stage 2 baby foods (semi-chunky):** ☐ **Regular table food** ☐
Baby cereal: ☐ **Stage 3 baby foods (chunky):** ☐

How is liquid presented?

☐ **breast**
☐ **bottle**
type of nipple

_____ cup
☐ **sippy cup**
☐ **cup with lid**
☐ **straw cup**
☐ **open cup**

Approximately how much liquid does your child drink at each meal? _____
Approximately how much food does your child eat at each meal? _____
How long does each meal take? _____
What do you do when your child does not eat appropriately? _____

_____

What are some "easy" or favorite foods for your child? _____

Which foods are "hard" or does your child REFUSE to eat? _____

List some GOOD things your child does at meal times (sits at the table, eats certain foods, etc.) _____

List some things you feel your child should be doing at meals that he/she does not do: _____

List some things you feel your child should not be doing at meals (having a tantrum, throwing food):

What have you tried to help your child with his/her feeding problem? _____