**Feeding Evaluation Intake Form**

**Client Name & Date:**

**Date of Birth:**

**Pediatrician:**

**Medical Record #:**

**Parents Names:**

**Address:**

**Cell phone & Email:**

**Medical Diagnosis:**

**Speech Diagnosis:**

**Primary concerns:**

How old was your child when eating/feeding became a problem?

Why do you think it became a problem?

List the foods your child is allergic to:

Please describe your expectations as a result of this evaluation:

Has your child received a medical diagnosis? If so please list all.

Who referred you for this evaluation and why?

**MEDICAL HISTORY**

Please X if there are issues in any of the following areas.

Hearing Loss

Sensory/Touch

Seizures

Vision

Gross-motor

Allergies

Heart

Fine-Motor

Aspiration

Feeding

Other:

Please describe in detail all that were indicated above:

Please describe your child’s health in general:

MEDICATIONS: please list all medications

Include name of Med, What addressing? Dosage Side Effects

1.

2.

3.

4.

HEARING:

Has your child had any ear infections? If so, please list dates and treatment.

List any hearing evaluations your child has had.

Date: Where: Results:

Do you have a follow up test scheduled?

**PRE-NATAL & BIRTH HISTORY:**

Please describe any pre-natal issues:

Please describe any relevant circumstances at birth.

**BACKGROUND INFORMATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referred by:**

**Birth History:**

Birth uneventful?

Birth eventful? Describe:

Premature? How many weeks?

Full term?

APGAR Score:

**Medical History: Please X & elaborate on all of the following that apply.**

Hospitalizations?

Surgeries?

Medications? please list:

Seizures?

# of Ear infections Treated with antibiotics? Resolved?

Frequent upper respiratory infections?

GERD? age diagnosed: How treated? Have symptoms resolved?

Constipation? age diagnosed: How treated? Have symptoms resolved?

Enlarged tonsils or adenoids?

History of choking?

History of vomiting associated with eating?

Eats well?

Picky eater?

Nutrition a concern? current weight? height?

Weight percentile: Height percentile:

Bottles fed per day? Number of ounces: Name of Formula:

Sleeps well? Snore? Please provide sleep schedule:

**Hearing Assessed?**  Where ? Age? Results?

**Developmental Milestones:**

Sat at age: Walked at age: First words at age:

**FEEDING HISTORY**

**Breast & Bottle Feeding**

Was your child breast-fed? When started and weaned?

Did your child latch on easily?

Have a strong or weak suck?

Lose liquid out the corners of the mouth? Please describe.

Was your child bottle-fed? From when to when?

What brand nipple and size did/do you use?

Have you switched nipples? Why?

During these early feedings, did your child arch, cry, spit up, gag, cough, vomit or pull off the nipple?

Please indicate the behaviors shown and describe when they would happen, why, or for how long:

Please describe your child’s current skill on breast or bottle:

If your child is weaned, please describe how the weaning process off the breast and/or bottle went and why the child was weaned:

**Solid Foods**

At what age did your child transition to:

baby cereal?

Baby food?

Finger foods?

Transition fully to table food?

Please describe how these transitions were handled by your child, especially if there were difficulties:

List the foods your child will currently eat and drink, divided into 3 categories Fruit & Vegetables, Carbohydrates & Proteins (put a star next to their favorites). Please indicate if it is only a specific brand.

Fruit and Vegetables:

Carbohydrates:

Proteins:

List the foods your child was eating but no longer accepts:

Describe your child’s mealtime:

Who usually feeds your child?

Who typically eats with your child?

What type of chair is used?

How long are meals typically?

Does your child use utensils or any type of special cups/bowls (describe)?

List the times your child typically eats and what type (bottle, breast, purees, food that requires chewing)?

Did/does your child mouth toys?

Does your child drool?

Does your child hold food in their mouth for excess period of time?

Does your child chew well?

**COMMUNICATION**

Does your child understand what you say? If so, please list the words your child understands.

Sounds and words: Does your child communicate using cry, sounds or words? Please list:

How else does your child communicate? Gestures, eye gaze (or aversion), facial expression, pushing food out of the mouth, etc. Please list all.

**FAMILY**

Names and ages of siblings.

Names and nicknames of family members close to your child: (ie: ‘nona’/grandmother):

Names of pets:

**SCHEDULE**

What time does your child nap?

Does your child attend any regularly scheduled appointments or programs?

Name : Days: Times:

1.

2.

3.

**Thank you for completely filling out this form. Please bring it with you to your appointment or you can email it to mbourneslp@gmail.com**