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Feeding Evaluation

What concerns do you have about your child's eating?

_____
_____
_____
_____

What do you hope to gain from this appointment?

_____
_____
_____
_____

GENERAL HISTORY

1. Is your child currently allowed to eat by mouth? Yes No
2. Is your child currently allowed to drink by mouth? Yes No
3. Does your child have any of the following symptoms when eating or drinking? (Please check all that apply.)

- gagging/coughing
- vomiting
- eats a limited variety of food/selective slow weight gain
- refuses to eat
- spits out food
- cries/screams
- other (specify)
- choking
- limited volume/not eating enough difficulty swallowing
- refuses to swallow/holds food in mouth difficulty progressing to table food does not remain seated
  throws food and/or utensils

4. At what age did your child's eating first become a concern? _____
5. Has your child been seen by any other specialists/therapists to help with Feeding?
    - Gastroenterology doctor
    - Ear, Nose, and Throat doctor
    - Early Intervention
    - Dietitian/Nutritionist
    - Outpatient Therapy
    - Speech Therapy
    - Other Feeding Program Alternative medicine provider Other
6. What strategies have you tried to deal with your child's eating problems?
    - distraction during meals (e.g. games, TV)
    - skipping meals
    - rewards
    - feeding child when s/he requests food coaxing
    - forcing
    - allowing child to drink more fluids giving preferred foods punishment
    - high calorie supplements/formula
    - other (specify)

      _____
      _____
      Please describe:

      _____
      _____
7. Was the baby in the NICU? Yes No If yes, why?
8. If yes, how long was your baby in the NICU?

   _____
9. Was your baby breast fed? Yes
   If yes, for how long? _____
   If yes, did you have difficulty breastfeeding? Yes No

   If yes, please explain:

   _____
   _____

10. Did your baby ever drink formula? Yes No
    If yes, what brand (s) of formula?
    _____
    If yes, did your child have difficulty bottle feeding? Yes No If yes, please explain:
    _____
    _____
11. At what age did you start spoon feeding? _____
    Did he/she have difficulty? Yes No
    If yes, please explain:
    _____
    _____

MEDICAL HISTORY

1. Please note any of your child's medical, developmental and/or mental health diagnoses.
    - GE reflux (heartburn)
    - failure to thrive/slow growth
    - pulmonary (lung) issues (asthma)
    - slow stomach emptying
    - eosinophilic esophagitis
    - developmental delay
    - cardiac (heart) issues
    - constipation
    - diarrhea
    - esophagitis
    - neurologic (brain)issues
    - renal (kidney) issues
    - autism/PDD
    - mental health (specify)_____
      _____
    - Genetic/chromosome abnormality (specify)
      _____
    - other (specify)
      _____
      _____

2. How often does your child have a bowel movement? daily every other day other _____

Does s/he have issues with: Constipation (hard stools) Yes No Diarrhea (loose stools) Yes No

3. Is your child allergic to or does he/she react to the following? If yes, please describe the reaction.

- Prescription medicines (Reaction: _____)
- Over the counter medicines, supplements, or herbal remedies (Reaction: _____)
- Foods, food additives, or drinks (Reaction: _____)
- Latex or anything else such as bandages or tape (Reaction: _____)
- X-ray, CT, MRI, or other radiology dyes (Reaction: _____)
- Blood products (Reaction: _____)
- None known

EATING ENVIRONMENT

1. Where does your child usually sit during mealtimes?
    - infant seat
    - child stands
    - on caretaker's lap
    - highchair
    - child wanders around
    - booster seat in front of TV
    - chair at table
    - held in caretaker's arms
    - other _____
2. Where in the house is your child fed?
    - kitchen
    - dining room
    - living room
    - walking around

- other (please specify)

  _____

3. With whom does your child usually eat/drink?
   - alone
   - with parents
   - with siblings
   - with peers
   - in the car
   - with nurse
4. At what other locations does your child eat/drink?
   - daycare
   - school
   - other relative's home
   - in the car

HOW DOES YOUR CHILD EAT/DRINK NOW?

1. Who feeds your child?
   - Mother
   - Father
   - Sibling
   - Grandparent
   - Nurse
   - Teacher Daycare provider
   - other (please specify) _____
2. Please note your child's current feeding skills.
   a. Spoon fed? Yes No If yes, type of spoon?

      _____

   b. Child feeds self? Yes No
      i. Finger feeding: beginning artially successful completely successful
      ii. Feeds self with spoon: beginning partially successful completely successful
      iii. Feeds self with fork: beginning partially successful completely successful

c. Drinking from breast? Yes No
d. Drinking from a bottle? Yes No
    i. If yes, what type of nipple:
        - regular
        - orthodontic
        - other (please specify)_____
    ii. How is your child positioned during feeding?
        - seated
        - held
        - other (please specify)_____
e. When is bottle/breast offered?
_____
f. Drinking from a cup? Yes No If yes, type of cup
_____
g. Straw drinking? Yes No

3. What does your child drink and how much?
    - Milk ounces per day (Type of Milk: _____)
    - Infant Formula ounces per day (Name of Formula: _____)
    - Water_____ounces per day
    - Nutritional Supplement_____ ounces per day (Name of Supplement: _____)
    - Juice _____ounces per day
    - Soda/tea _____ounces per day
    - Other_____

Food Textures

1. Please check (√) your child's current ability to eat a variety of food textures:

Texture	**Eats easily**	**Eats with difficulty**	**Refuses**	**Cannot eat**	**Never tried**
Baby food					
Pureed table food					
Mashed table food					

Dissolvables (e.g. puffs, veggie sticks, Cheerios)					
Chopped table food					
Soft table food (e.g. pancakes)					
Crunchy table food (e.g. apple, crackers)					
Difficult to chew table food (e.g. meat)					

2. Please give examples of food your child will eat from all food groups

Food/Group	Examples
Fruits	
Vegetables	
Grains (breads/cereals/pasta/rice)	
Meats/eggs/peanut butter	
Dairy (milk, cheese, yogurt)	

DIET ASSESSMENT

Please list everything your child might eat or drink during a typical day.
Describe all food, formula, drinks, snacks, food extras (butter, oil, salad dressing) *that are offered AND the amounts actually eaten.*

Food	**How much offered**
Example: Stage 2 carrots	4 ounce jar
Example: whole milk with heavy cream	6 ounces + 1 tablespoon
Example: Chewy granola bar	1⁄4 of the bar

Breakfast	**Amounts of Food/Drink Child actually eats/ drinks**

Snack	**Amounts of Food/Drink Child actually eats/ drinks**

Lunch	**Amounts of Food/Drink Child actually eats/ drinks**

Snack	**Amounts of Food/Drink Child actually eats/ drinks**
Dinner	**Amounts of Food/Drink Child actually eats/ drinks**

Bedtime Snack	**Amounts of Food/Drink Child actually eats/ drinks**