Pediatric Feeding Institute
South Florida

HISTORY AND FEEDING INTAKE FORM
Please complete the entire form before your initial evaluation.

Child's Name: _____

Today's Date: _____ Date of Birth: _____

Born at: _____ Birth weight: _____

□ Full term □ Premature _____ # weeks at birth

Hospitalizations, Surgeries: _____

Caregiver's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____ Relationship to Child: _____

Child's Height_____ Weight: _____ Date Taken: _____

Previous Therapy Provider/School: _____

Primary Physician: _____

Address: _____

City, State, Zip: _____ Phone: _____

Pediatric Specialist Physicians: _____

Please circle all that apply:
1. Food Refusal date started: _____

2. Food Selectivity date started: _____

3. Oral Motor Delays (drooling, difficulty chewing) Specify: _____

4. Dysphagia (Choking, coughing with food or liquids) date started:_____

5. Food Selected by temperature, brand, specific utensil/cup date started: ____

Pediatric Feeding Institute
South Florida

Please circle all the foods eaten by your child and family.

FOOD	Child	Family	FOOD	Child	Family	FOOD	Child	Family
Apple	Y N	Y N	Milkshake	Y N	Y N	Pork	Y N	Y N
Apple juice	Y N	Y N	Other cheese	Y N	Y N	Roast Beef	Y N	Y N
Applesauce	Y N	Y N	Pudding	Y N	Y N	Sausage	Y N	Y N
Apricots	Y N	Y N	Sherbet	Y N	Y N	Shrimp	Y N	Y N
Avocado	Y N	Y N	Sour cream	Y N	Y N	Steak	Y N	Y N
Banana	Y N	Y N	Tofu	Y N	Y N	Tuna Salad	Y N	Y N
Berries	Y N	Y N	Yogurt	Y N	Y N	Turkey	Y N	Y N
Cantaloupe	Y N	Y N	Crackers	Y N	Y N	Veal	Y N	Y N
Cherries	Y N	Y N	Fruit Snacks	Y N	Y N	Chili	Y N	Y N
Cranberry juice	Y N	Y N	Candy	Y N	Y N	Pot Pie	Y N	Y N
Fruit Cocktail	Y N	Y N	Pie	Y N	Y N	Soup	Y N	Y N
Grapefruit juice	Y N	Y N	Potato chips	Y N	Y N	Stuffing	Y N	Y N
Grapes	Y N	Y N	Pretzels	Y N	Y N	Bagel	Y N	Y N
Grape juice	Y N	Y N	Bacon	Y N	Y N	Breakfast Bars	Y N	Y N
Honeydew	Y N	Y N	Baked beans	Y N	Y N	Cereal	Y N	Y N
Kiwi	Y N	Y N	Chicken	Y N	Y N	Asparagus	Y N	Y N
Lemonade	Y N	Y N	Chicken nuggets	Y N	Y N	Beets	Y N	Y N
Mango	Y N	Y N	Chicken salad	Y N	Y N	Broccoli	Y N	Y N
Nectarine	Y N	Y N	Clams	Y N	Y N	Cabbage	Y N	Y N
Oranges	Y N	Y N	Crab/lobster	Y N	Y N	Carrots	Y N	Y N
Orange juice	Y N	Y N	Eggs	Y N	Y N	Cauliflower	Y N	Y N
Peaches	Y N	Y N	Fish	Y N	Y N	Coleslaw	Y N	Y N
Pear	Y N	Y N	Fish Sticks	Y N	Y N	Celery	Y N	Y N
Pineapple	Y N	Y N	Ham	Y N	Y N	Corn	Y N	Y N
Plums	Y N	Y N	Ham Salad	Y N	Y N	Creamed Corn	Y N	Y N
Prunes	Y N	Y N	Hamburger	Y N	Y N	Cucumbers	Y N	Y N
Prune juice	Y N	Y N	Hot Dog	Y N	Y N	Greens	Y N	Y N
Strawberries	Y N	Y N	Lamb	Y N	Y N	Green Beans	Y N	Y N
Raisins	Y N	Y N	Lentils	Y N	Y N	Lettuce	Y N	Y N
Watermelon	Y N	Y N	Liver	Y N	Y N	Lima Beans	Y N	Y N
American cheese	Y N	Y N	Lunchmeat	Y N	Y N	Onions	Y N	Y N
Cheese spread	Y N	Y N	Meatloaf	Y N	Y N	Peas	Y N	Y N
Chocolate milk	Y N	Y N	Other Beans	Y N	Y N	Green Pepper	Y N	Y N
Cottage cheese	Y N	Y N	Nuts	Y N	Y N	Pickles	Y N	Y N
Cream cheese	Y N	Y N	Peanut Butter	Y N	Y N	Spinach	Y N	Y N
Ice cream	Y N	Y N	Peanuts	Y N	Y N	Squash	Y N	Y N
Milk	Y N	Y N	Popcorn	Y N	Y N	Sweet Potato	Y N	Y N
Cake	Y N	Y N	Grits	Y N	Y N	Poptart	Y N	Y N
Cheese Puff	Y N	Y N	Lasagna	Y N	Y N	Mashed/baked potato	Y N	Y N
Chocolate	Y N	Y N	Ravioli	Y N	Y N	Potato salad	Y N	Y N
Cookies	Y N	Y N	Macaroni	Y N	Y N	Ramen noodles	Y N	Y N
Corn Chips	Y N	Y N	Muffins	Y N	Y N	Rice	Y N	Y N
Cream of Wheat	Y N	Y N	Rolls	Y N	Y N	Spaghetti	Y N	Y N
Donut	Y N	Y N	Noodles	Y N	Y N	Taco/burrito	Y N	Y N

Egg Noodles	Y N	Y N	Oatmeal	Y N	Y N	Waffle	Y N	Y N
Farina	Y N	Y N	Pancake	Y N	Y N	Wheat bread	Y N	Y N
French Fries	Y N	Y N	Pita	Y N	Y N	White bread	Y N	Y N
French Toast	Y N	Y N	Pizza	Y N	Y N	other	Y N	Y N

DRINKING:

Does your child drink from: open cup sippie cup straw bottle

Does your child require a liquid supplement: YES NO

If yes, which one? _____ How much/day?_____

What kind of milk does your child consume: Whole 2% 1% Skim Soy Rice Oat

How many ounces of milk does your child consume in a day? _____

How much juice does your child consume in a day? _____

Does your child drink liquid that contains caffeine? YES NO If yes, how many ounces each day?____

Does your child drink water? YES NO If yes, how many ounces each day? _____

What are your goals? Check all that apply.

Increase the volume of food my child eats ___
Increase the variety of food my child eats ___
Improve oral motor skills ___
Increase weight gain ___
Decrease gagging/vomiting during meals ___
Improve cup drinking ___
Improve mealtime behaviors ___
Decrease tube dependency ___
Other ___

Where does your child eat? Caregiver's lap Booster Seat Infant Seat

High Chair Chair at table Walking

Other

What behaviors are seen at mealtime?

Throws food Spits out food Cries Leaves Table

Messy eater Refuses to eat Refuses to self feed Other

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South Florida

How many times in the last week did any of these occur?

How many meals did your child eat without a caregiver? Never 1-2 3-4 5 or more

How many meals does your child eat with T.V. on? Never 1-2 3-4 5 or more

How many times did you make a separate meal for child? Never 1-2 3-4 5 or more

How often did your child request food? Never 1-2 3-4 5 or more

Please check all that are applicable:

Consistency	Can Eat	Never Tried	Can't Eat
Liquids/soups			
Stage 1-2 baby food			
Stage 3 baby food			
Pureed table food			
Mashed table food			
Regular table food			
Crisp food (e.g.chip/cracker)			
Soft solids (e.g.banana)			
Other			

Meal Pattern

How long does it take for your child to finish a meal? _____

Describe your child's appetite. _____

Do you praise your child for eating? _____ How? _____

Do you send your child away from the table when they are not eating? YES NO

Do you give your child the option of another food when he/she refuses what is served? YES NO

Does your child indicate hunger? YES NO How? _____

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South Florida

Tube Feeding

Were any of these ever used? NG tube nasal cannula tracheotomy tube G-tube

Type of feeding tube? _____ Type of formula used?_____

How many calories does your child consume each day? _____

Does your child receive any other liquid/food through their tube? YES NO

If yes, what? _____

Does your child require: Continuous feeding YES NO How much/hour? _____

Bolus Feeds: What is the schedule? _____

Volume/bolus_____ How long does feeding take? _____

Does your child gag/vomit during tube feedings? YES NO

If yes, how often? _____

Does your child have a Nissen Fundoplication? YES NO

Please circle all that apply. My child experiences problems with:

Constipation Diarrhea Sleeping

Describe:_____
_____
_____

Please circle all that apply

Poor tongue control Poor lip control Swallowing problems Teeth grinding

Coughing/gagging Problems with biting Lack of chewing Hypersensitive

Drooling Poor Sucking Vomiting

Other: _____

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Diagnosis
Does your child have a diagnosis? _____

Diagnosis		Food Allergies	Y/N
Autism, PDD	Y/N	Lactose Intolerant	Y/N
Developmental Delay	Y/N	Vision Impairment	Y/N
ADHD	Y/N	Hearing Deficit	Y/N
Mental Retardation	Y/N	Delayed Gastric Emptying	Y/N
Traumatic Brain Injury	Y/N	G-tube/J-tube dependency	Y/N
Anxiety/OCD	Y/N	Heart Problems	Y/N
Spina Bifida	Y/N	Asthma	Y/N
Cerebral Palsy	Y/N	Oxygen dependent	Y/N
Cleft Lip/Palate	Y/N	Tracheotomy	Y/N
Seizure Disorder	Y/N	Learning Disability	Y/N
Diabetes	Y/N	Sensory Integration Dysfunction	Y/N
Prematurity	Y/N	Chronic Constipation	Y/N
Reflux	Y/N	Chronic Diarrhea	Y/N

Other: _____

Please list all medications your child is taking: _____
_____

Please list all allergies: _____

Feeding Skills: Circle all that apply.

_____ Drinks from bottle _____ held by caregiver _____ independently

_____ Self feeds with fingers

_____ Uses a spoon _____ with assistance _____ independently

_____ Uses a fork _____ with assistance _____ independently

_____ drinks from open cup _____ with assistance _____ independently

_____ Drinks from sippie cup _____ with assistance _____ independently

Hand preference: Left Right

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Positioning/Seating

Is your child in a wheelchair or an adaptive seat? YES NO

Please describe: _____

How much of the day does your child spend in this chair? _____

Do you have a separate feeding chair? YES NO

If yes, describe: _____

Please use this space to tell us about your child:

_____
_____
_____
_____
_____
_____

Please contact us (561) if there are any questions regarding the information on this form. We look forward to working with you and your child!