SPEECH, LANGUAGE AND FEEDING DEPARTMENT
Feeding History

Patient Name: ______________________________ Person Completing Form: ______________________ Date: __________

Your concerns about your child's feeding:
____
____
____
____

CHECK ANY FACTORS LISTED BELOW THAT APPLY:

Methods/utensils currently used:

_____ Breast
_____ Bottle/type of nipple used? ____________
_____ Cup/type(s) used? ___________________
_____ Spoon/type(s) used? _________________
_____ Fork
_____ Straw
_____ Fingers
_____ Tube feedings/type? _________________
% of intake by tube _________________
_____ Other: _________________________

Textures currently accepted:

_____ Formula: _________________________
_____ Other thin liquids: __________________
____
_____ Thick liquids
_____ Commercial baby food
____ Stage I
____ Stage II
____ Stage III
_____ Ground or commercial junior food
_____ Food prepared in the blender
_____ Mashed soft table food
_____ Regular table foods (includes chewable)
_____ Only accepts certain types of foods (list)
____
____
_____ Other: _____________________________

Feeding and sensory behaviors:

_____ Does not eat anything by mouth
_____ Problems gaining weight
_____ Takes insufficient amount
_____ Falls asleep while feeding
_____ Refuses (turns away, cries, wants down)
_____ Forgets to breathe while feeding
_____ Arches/draws legs up to stomach
_____ Changes color around face/mouth with feeding
_____ Snacks throughout the day
_____ Plays during mealtime
_____ Easily distractable
_____ Will not stay seated while eating
_____ Gags/vomits with new textures/tastes
_____ Throws food/utensils
_____ Does not like to be messy
_____ Does not like to be fed by others
_____ Will not/cannot self-feed (if expected for age)
_____ Difficulty chewing
_____ Coughs/chokes with eating textures
How often? ____________________________
_____ Sounds congested/wet with eating
_____ Vomits during/shortly after/well after mealtime
_____ Other: _______________________________

Mealtime:

Duration (in minutes):
____ 15 ____ 30 ____ 45 ____ 60 ____ >1 hour

Where is your child fed?
_____ On your lap
_____ In chair/type? ____________________________
_____ In bed
_____ Other position(s): ___________________________

Person(s) who typically feed child: __________________
____

Schedule: (For infant)

Intake amount: __________ Approximately every ____ hrs.
Estimated total per 24 hours: ______________________
How do you know your baby is ready to eat? ___________
____

Sleep/wake pattern: ______________________________
____

Schedule: (For toddler and older)

Time: Meal/snack	Typical foods:	Amount:

What would you like to find out from today's evaluation?
____
____
____
____

Other professionals with whom you have discussed your child's feeding: ____________________________
____

Patient ID

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