Feeding History

Child's Name: _____

Please tell about your current feeding concerns:

_____

_____

_____

Gastrointestinal History

History of GI deficits? NO ☐ YES:_____

History of GI surgery? NO ☐ YES: _____

History of Reflux? NO ☐ YES: _____

Has your child **previously** received alternative feeds? NO ◯ YES ◯

If YES, please circle all that apply:

NG Tube ☐ G-Tube ☐ J-Tube ☐ PEG Tube ☐ PEJ Tube ☐ TPN ☐ Bolus ☐ Cont Drip ☐ Combo ☐

Other:_____

Does your child **currently** receive alternative feeds? NO ◯ YES ◯

If YES, please circle all that apply:

NG Tube ☐ G-Tube ☐ J-Tube ☐ PEG Tube ☐ PEJ Tube ☐ TPN ☐ Bolus ☐ Cont Drip ☐ Combo ☐

Other:_____

Has your child ever had any of the following tests? If yes, please indicate most recent results.

- Upper GI NO ☐ YES:_____
- Endoscopic Evaluation of Swallowing NO ☐ YES:_____
- Barium Swallow NO ☐ YES:_____
- Modified Barium Swallow NO ☐ YES:_____

Are there current concerns about weight gain or weight loss? NO ☐ YES:_____

Craniofacial/Dental History

Does your child have any of the following? If yes, please explain in space provided.

- Defects of the lip and/or palate? NO ☐ YES:_____
- Lip and/or palate surgeries? NO ☐ YES:_____
- History of sinus infections? NO ☐ YES:_____
- Diagnosed genetic syndrome? NO ☐ YES:_____
- Food or liquid coming out of nose? NO ☐ YES:_____
- Dental abnormalities? NO ☐ YES:_____
- Dental surgeries? NO ☐ YES:_____

Does your child receive routine dental care? YES ◯ NO ◯

Are your child's teeth brushed daily? YES ◯ NO ◯

Who brushes your child's teeth? (Circle) Child ☐ Parent/Caregiver ☐

How does your child react to tooth brushing? (Circle) Enjoys ◯ Resists ◯ Other:_____

Child's Name: _____

Feeding History

Liquids:

Does your child require liquids to be thickened? NO YES
Does your child cough or choke with liquids? NO YES
Does your child sound gurgly while drinking or immediately after? NO YES

How does your child consume liquids? (Circle all that apply)
Breast Bottle No-Spill Cup Straw Open Cup Other:_____

What types of liquid are regularly consumed? (Circle all that apply)
Water Breastmilk Formula Milk Juice Soda Other:_____

Solids:

Does your child cough, choke, or gag with food? NO YES
Does your child sound gurgly while eating or immediately after? NO YES
Does your child require specialized feeding equipment? NO YES
Would you consider your child to be a "picky eater"? NO YES
Do you have concerns about the variety of food your child eats? NO YES

How does your child eat solids? (Circle all that apply)
Fingers by caregiver Utensils by caregiver Fingers by self Utensils by self

Please circle the types of food consistency that are regularly consumed: (Circle all that apply)
Thin puree (i.e. baby food) Soft solids (i.e cheese, raisins)
Puree (i.e. pudding) Multiple consistencies (i.e. cereal with milk)
Dissolvable solids (i.e. puffs) Difficult to chew foods (i.e. meat, raw vegetables)

Please indicate the variety of foods your child will eat: (Circle the frequency)

Fruits:	Never	Rarely	Sometimes	Often
Vegetables:	Never	Rarely	Sometimes	Often
Grains:	Never	Rarely	Sometimes	Often
Dairy:	Never	Rarely	Sometimes	Often
Meats:	Never	Rarely	Sometimes	Often

Does your child tend to crave or reject certain smells pertaining to food? (If yes, explain)
NO YES:_____

Does your child tend to crave or reject certain tastes pertaining to food? (If yes, explain)
NO YES:_____

Mealtime Routines

Do you prepare special meals for your child? NO YES
Do you feel you have to play games to get your child to eat? NO YES
Do you feel you have to reward your child to get them to eat? NO YES
Does your child eat at the same time and place as the family? NO YES
Does your child stay seated for the entire meal time? NO YES

How long are meal times in general?_____

How many planned meals/snacks does your child receive daily?_____

What type of chair does your child sit in for most meals at home? _____