Carbon Lehigh Intermediate Unit #21

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Feeding and Swallowing Intake
(Completed by Parent)

Child's Name: _____ **Date of Birth:** _____

Date: _____

BIRTH HISTORY

Birth weight: _____

Full-Term Pregnancy? ☐ Yes ☐ No

If no, how many weeks gestation? _____

Problems during the pregnancy? ☐ Yes ☐ No

If yes, please describe:

Problems immediately following the birth? ☐ Yes ☐ No

If yes, please describe:

MEDICAL HISTORY

Diagnosis: _____

Primary Care Physician: _____

Other Physicians treating child: _____

Cleft palate or other craniofacial anomalies? ☐ Yes ☐ No

Respiratory difficulties? ☐ Yes ☐ No

If yes, please describe:

Helping Children Learn

"CLIU is a service agency committed to Helping Children Learn."

Feeding and Swallowing Intake (Completed by Parent)
Child's Name:

MEDICAL HISTORY (continued)

Allergies (Food/Environment)? ☐ Yes ☐ No

If yes, please describe:

Pneumonia? ☐ Yes ☐ No

If yes, please describe:

Cardiac problems? ☐ Yes ☐ No

If yes, please describe:

Seizures? ☐ Yes ☐ No

If yes, describe type, frequency and medication:

Surgeries? ☐ Yes ☐ No

If yes, please describe:

Hospitalizations? ☐ Yes ☐ No

If yes, please describe:

Medications? ☐ Yes ☐ No

If yes, please describe:

DEVELOPMENTAL HISTORY (Please indicate ages)

Sitting unsupported: _____ **Crawling:** _____

Standing alone: _____ **Walking:** _____

FEEDING HISTORY

Was the child breast fed? ☐ Yes ☐ No

Was the child fed through a feeding tube? ☐ Yes ☐ No

If so, for how long? _____

Feeding and Swallowing Intake (Completed by Parent)
Child's Name:

EATING HABITS

What does your child eat in a typical day? List main foods and amounts per meal.

Breakfast:	
Morning Snack:	
Lunch:	
Afternoon Snack:	
Dinner:	
Evening Snack:	

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

What are your child's favorite foods and consistencies?

What foods/consistencies does your child dislike/avoid?

In what position is your child most comfortable eating? *(Please check all that apply.)*

☐ Highchair ☐ Chair at table ☐ Standing ☐ Lap
☐ Laying Down ☐ Other: _____

What utensils have been introduced? Please indicate at what age. *(Please check all that apply.)*

☐ Pacifier ☐ Bottle ☐ Fingers ☐ Spoon ☐ Fork
☐ Sippy Cup ☐ Straw ☐ Regular Cup ☐ Cup

Is any adaptive equipment being used during feeding? ☐ Yes ☐ No

If yes, please describe:

If your child is not using a bottle, when did they transition to cup? _____

Does your child self-feed? ☐ Yes ☐ No

At what age did your child start self- feeding? _____

If your child is dependent for feeding, how long does a typical feeding last? _____

What kinds of food does your child eat regularly? Please indicate at what age. *(Please check all that apply.)*

☐ Breastmilk ____ ☐ Formula ____ ☐ Thin Liquids ____ ☐ Thickened Liquids ____
☐ Pureed food ____ ☐ Mashed table food ____ ☐ Chopped table food ____ ☐ Regular table food ____
☐ Other: _____ ____

EATING HABITS (continued)

If your child is eating solids, at what age was solid food introduced? _____

Does your child take any nutritional supplements? ☐ Yes ☐ No

If yes, please indicate the product, amount, and frequency.

How do you know when your child is hungry? _____

How do you know when your child is full? _____

Is your child losing weight? ☐ Yes ☐ No

Is your child have trouble gaining weight? ☐ Yes ☐ No

Has your child been diagnosed with Reflux or any other GI problems? ☐ Yes ☐ No If yes, what diagnosis:

Has your child had a fluoroscopy/swallow studies? ☐ Yes ☐ No

If yes, when? _____

Has your child had prior feeding therapy/intervention? ☐ Yes ☐ No

If yes, when and where? _____

Does your child have regular bowel movements? ☐ Yes ☐ No

Any other concerns?

Please check off any behaviors that apply to your child *during* meals. *(Please check all that apply.)*

☐ Choking	☐ Pocketing food in mouth	☐ Food or liquid coming out of nose	☐ Difficulty in swallowing
☐ Eats too much	☐ Eats too little	☐ Fussy, cranky	☐ Trouble breathing
☐ Spitting out food	☐ Gagging	☐ Pushing out food	☐ Noisy breathing
☐ Crying	☐ Wet quality to voice	☐ Holding food in mouth	☐ Falling asleep
☐ Refusal to eat	☐ Stiffening	☐ Vomiting	☐ Mouth closing
☐ Hyperextension	☐ Head turning	☐ Other: _____	

Does your child demonstrate negative behaviors *during* mealtime? *(Please check all that apply.)*

☐ Takes food from other's plate	☐ Trouble with chewing	☐ Trouble with swallowing	☐ Spits food out
☐ Leaves table before done	☐ Refusal to eat	☐ Messy eater	☐ Throws food
☐ Trouble with self-feeding	☐ Other: _____		

Does your child still use a pacifier? ☐ Yes ☐ No

Does your child dislike being touched around his/her mouth? ☐ Yes ☐ No

Does your child drool? ☐ Yes ☐ No

If yes, how often? ☐ Infrequent ☐ Occasionally

What seems to help (or not help) your child during mealtime?