



FEEDING INTAKE FORM

Name: _____ Date of Birth: _____

PTI #: 806-793-3900 Social Security #: _____

Caregiver's Name: _____

Address: _____

City, State, Zip: _____ Telephone: _____

Educational Service Provider: _____

(school or early intervention agency)

Does your child have any of the following problems? Please include when each problem started.

_____ Food refusal (refusing all or most food)
Onset: _____

_____ Food selectivity by texture (eating only textures that are not developmentally appropriate)
Onset: _____

_____ Food selectivity by type (eating only a narrow variety of foods)
Onset: _____

_____ Oral motor delays (problems with chewing, lip closure, or tongue lateralization)
Onset: _____

_____ Dysphagia (problems with swallowing)
Onset: _____

_____ Abnormal preferences (e.g. refuses food if not a certain temperature, eats only certain brands, must have a certain cup or special silverware to eat)
Describe: _____ Onset: _____

_____ Other feeding problem (describe): _____

_____ Speech-language difficulties (talked late, difficult to understand, difficulties with school): _____

Feeding History:

What issues are you trying to resolve? (Check as many as apply):

<input type="checkbox"/>	Increase the volume of food my child eats	<input type="checkbox"/>	Increase the texture of food my child eats
<input type="checkbox"/>	Increase the variety of foods my child eats	<input type="checkbox"/>	Improve cup drinking
<input type="checkbox"/>	Improve oral motor skills	<input type="checkbox"/>	Improve mealtime behaviors
<input type="checkbox"/>	Decrease gagging during eating	<input type="checkbox"/>	Decrease vomiting related to eating
<input type="checkbox"/>	Reduce/eliminate diarrhea	<input type="checkbox"/>	Reduce/eliminate constipation
<input type="checkbox"/>	Increase weight gain	<input type="checkbox"/>	Decrease tube feedings
<input type="checkbox"/>	Resolve reflux or other GI issues	<input type="checkbox"/>	Other _____

Was feeding interrupted at any time in the child's history? _____ yes _____ no

a. For how long? _____

b. For what reason? _____

Feeding Environment

What do you do when your child has behavior problems during a meal?

Feeding Practices

a. At what age were solids introduced? _____

b. Was a nipple/pacifier used during neonatal period? _____yes _____no

c. During infancy, was child fed by bottle_____, breast_____, combination_____

d. Note reason for refusal of any foods: _____

e. Describe any special diet: _____

If your child is already working with a therapist on feeding or oral motor development, please have the therapist complete the attached oral-motor function checklist. If your child does not have a therapist, please disregard.

Associated Feeding Problems

Estimate the frequency of occurrence for each of the following per day:

- a. _____ Vomiting/rumination
- b. _____ Teeth grinding
- c. _____ Coughing
- d. _____ Gagging
- e. _____ profuse perspiration (diaphoresis)

Were any of the following used during infancy period? (please circle)

Tracheotomy tube NG tube Nasal cannula Gastrostomy tube

Food Preference Inventory

Circle about how often your child eats at least a portion of this food (the portion is listed after the food);
 No = a portion of this food is never eaten; Week = at least once per week; Day = once per day, Many = more than once per day. If the child eats other foods not included here, write them in the blanks below.

Food	How often is food eaten by your child?	Is this food eaten by the family?	Food	How often is food eaten by your child?	Is this food eaten by the family?
Apple	No Week Day Many	Yes	Crackers	No Week Day Many	Yes
Apple Juice	No Week Day Many	Yes	Fruit Roll-up/Snacks	No Week Day Many	Yes
Applesauce	No Week Day Many	Yes	Other Candy	No Week Day Many	Yes
Apricots	No Week Day Many	Yes	Pie	No Week Day Many	Yes
Avocado	No Week Day Many	Yes	Potato Chips	No Week Day Many	Yes
Banana	No Week Day Many	Yes	Pretzels	No Week Day Many	Yes
Banana Chips	No Week Day Many	Yes	Bacon	No Week Day Many	Yes
Berries	No Week Day Many	Yes	Baked Beans	No Week Day Many	Yes
Cantaloupe	No Week Day Many	Yes	Chicken	No Week Day Many	Yes
Cherries	No Week Day Many	Yes	Chicken Nugget	No Week Day Many	Yes
Cranberry Sauce	No Week Day Many	Yes	Chicken salad	No Week Day Many	Yes
Cranberry Juice	No Week Day Many	Yes	Clams/oysters	No Week Day Many	Yes
Fruit Cocktail	No Week Day Many	Yes	Crab/lobster	No Week Day Many	Yes
Grapefruit	No Week Day Many	Yes	Eggs	No Week Day Many	Yes
Grapefruit Juice	No Week Day Many	Yes	Fish	No Week Day Many	Yes
Grapes	No Week Day Many	Yes	Fish Stick	No Week Day Many	Yes
Grape Juice	No Week Day Many	Yes	Ham	No Week Day Many	Yes
Honeydew	No Week Day Many	Yes	Ham salad	No Week Day Many	Yes
Kiwi	No Week Day Many	Yes	Hamburger	No Week Day Many	Yes
Lemonade	No Week Day Many	Yes	Hot Dog	No Week Day Many	Yes
Mango	No Week Day Many	Yes	Lamb	No Week Day Many	Yes
Nectarine	No Week Day Many	Yes	Lentils	No Week Day Many	Yes
Oranges	No Week Day Many	Yes	Liver	No Week Day Many	Yes
Orange Juice	No Week Day Many	Yes	Lunchmeat	No Week Day Many	Yes
Peaches	No Week Day Many	Yes	Meatloaf	No Week Day Many	Yes
Pear	No Week Day Many	Yes	Other Beans	No Week Day Many	Yes
Pineapple	No Week Day Many	Yes	Other nuts/seeds	No Week Day Many	Yes
Plums	No Week Day Many	Yes	Peanut Butter	No Week Day Many	Yes
Prunes	No Week Day Many	Yes	Peanuts	No Week Day Many	Yes
Prune Juice	No Week Day Many	Yes	Popcorn	No Week Day Many	Yes
Strawberry	No Week Day Many	Yes	Pork	No Week Day Many	Yes
Raisins	No Week Day Many	Yes	Roast Beef	No Week Day Many	Yes
Watermelon	No Week Day Many	Yes	Sausage	No Week Day Many	Yes
American Cheese	No Week Day Many	Yes	Shrimp	No Week Day Many	Yes
Cheese Spread	No Week Day Many	Yes	Steak	No Week Day Many	Yes
Chocolate Milk	No Week Day Many	Yes	Tuna salad	No Week Day Many	Yes
Cottage Cheese	No Week Day Many	Yes	Turkey	No Week Day Many	Yes

Cream Cheese	No Week Day Many	Yes	Veal	No Week Day Many	Yes
Hot Chocolate	No Week Day Many	Yes	Venison	No Week Day Many	Yes
Ice Cream	No Week Day Many	Yes	Chili	No Week Day Many	Yes
Milk	No Week Day Many	Yes	Pot Pie	No Week Day Many	Yes
Milk Shake	No Week Day Many	Yes	Soup	No Week Day Many	Yes
Other Cheese(s)	No Week Day Many	Yes	Stew	No Week Day Many	Yes
Pudding	No Week Day Many	Yes	Stuffing	No Week Day Many	Yes
Sherbet	No Week Day Many	Yes	Bagel	No Week Day Many	Yes
Sour Cream	No Week Day Many	Yes	Breakfast Bars	No Week Day Many	Yes
Tofu	No Week Day Many	Yes	Cereal (cold)	No Week Day Many	Yes
Yogurt	No Week Day Many	Yes	Corn Bread	No Week Day Many	Yes
Asparagus	No Week Day Many	Yes	Cream of Wheat	No Week Day Many	Yes
Beets	No Week Day Many	Yes	Donut/pastry	No Week Day Many	Yes
Broccoli	No Week Day Many	Yes	Egg Noodles	No Week Day Many	Yes
Cabbage	No Week Day Many	Yes	Farina	No Week Day Many	Yes
Carrots	No Week Day Many	Yes	French Fries	No Week Day Many	Yes
Cauliflower	No Week Day Many	Yes	French Toast	No Week Day Many	Yes
Coleslaw	No Week Day Many	Yes	Grits	No Week Day Many	Yes
Celery	No Week Day Many	Yes	Lasagna/ravioli	No Week Day Many	Yes
Corn	No Week Day Many	Yes	Macaroni	No Week Day Many	Yes
Creamed Corn	No Week Day Many	Yes	Muffins/rolls	No Week Day Many	Yes
Cucumbers	No Week Day Many	Yes	Noodles	No Week Day Many	Yes
Greens	No Week Day Many	Yes	Oatmeal	No Week Day Many	Yes
Green or Wax Beans	No Week Day Many	Yes	Pancake	No Week Day Many	Yes
Lettuce (salad)	No Week Day Many	Yes	Pita	No Week Day Many	Yes
Lima beans	No Week Day Many	Yes	Pizza	No Week Day Many	Yes
Onion	No Week Day Many	Yes	Poptart	No Week Day Many	Yes
Peas	No Week Day Many	Yes	Potato(mashed/baked)	No Week Day Many	Yes
Green Pepper	No Week Day Many	Yes	Potato salad	No Week Day Many	Yes
Pickles	No Week Day Many	Yes	Ramen Noodles	No Week Day Many	Yes
Radish	No Week Day Many	Yes	Rice	No Week Day Many	Yes
Sauerkraut	No Week Day Many	Yes	Spaghetti	No Week Day Many	Yes
Spinach	No Week Day Many	Yes	Spaghettios	No Week Day Many	Yes
Squash	No Week Day Many	Yes	Stuffing/filling	No Week Day Many	Yes
Sweet Potato	No Week Day Many	Yes	Taco/burrito	No Week Day Many	Yes
Tomato	No Week Day Many	Yes	Waffle	No Week Day Many	Yes
Turnip	No Week Day Many	Yes	Wheat/grain Bread	No Week Day Many	Yes
Cake (any type)	No Week Day Many	Yes	White Bread	No Week Day Many	Yes
Cheese Puffs/Curls	No Week Day Many	Yes			
Chocolate Candy	No Week Day Many	Yes			
Cookies	No Week Day Many	Yes			
Corn/tortilla Chips	No Week Day Many	Yes			

Drinking Preference Inventory (circle or fill-in the blank; 1 cup = 8 ounces)

Does your child drink a supplement (e.g. Pediasure, Boost, etc.)? Yes No

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

What kind of milk does your child usually drink? Whole 2% 1% Skim Soy Rice

How much/day? _____

Is your child's milk usually flavored? Yes No

If yes, what is used? Chocolate/strawberry syrup Flavored powder Instant Breakfast
Ovaltine Other _____

Does your child drink? Hot chocolate Milkshake Drinkable yogurt

How many ounces of these drinks does your child drink per day? _____ ounces

How much 100% juice does your child drink per day? _____ ounces

How much other fruit drinks (Hi-C, Kool Aid, etc.) does your child drink per day? _____ ounces

How much soda or iced tea does your child drink per day? _____ ounces

Does it usually have caffeine? Yes No What type is it usually? Regular Diet

How much water does your child drink per day? _____ ounces

What issues are you trying to resolve? (Check as many as apply)

<input type="checkbox"/>	Increase the volume of food my child eats	<input type="checkbox"/>	Increase the texture of food my child eats
<input type="checkbox"/>	Increase the variety of foods my child eats	<input type="checkbox"/>	Improve cup drinking
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<input type="checkbox"/>	Reduce/eliminate diarrhea	<input type="checkbox"/>	Reduce/eliminate constipation
<input type="checkbox"/>	Increase weight gain	<input type="checkbox"/>	Decrease tube feedings
<input type="checkbox"/>	Resolve reflux or other GI issues	<input type="checkbox"/>	Other

Was feeding interrupted at any time in the child's history? Yes No

a. For how long? _____

b. For what reason? _____

Where does the child eat? (Check all that apply)

<input type="checkbox"/>	Caregiver's lap	<input type="checkbox"/>	Booster seat	<input type="checkbox"/>	Infant seat
<input type="checkbox"/>	High chair	<input type="checkbox"/>	Chair at the table	<input type="checkbox"/>	Other

Does the child have any of these issues at mealtimes? (circle all that apply)

<input type="checkbox"/>	Throws food during meal	<input type="checkbox"/>	Messy eater
<input type="checkbox"/>	Spits out food	<input type="checkbox"/>	Takes food from others
<input type="checkbox"/>	Cries or screams at meal	<input type="checkbox"/>	Refuses to self-feed
<input type="checkbox"/>	Leaves the table before finished	<input type="checkbox"/>	Overeats

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

	Never	1-2 meals	3-4 meals	5+meals
How many meals did your child eat without an adult?				
How many meals did your child eat with the T.V. on?				
How often did you make your child a separate meal because he/she would not eat the family meal?				
How many meals eaten at home were with peers or siblings?				
How often did your child request food other than at scheduled meal or snack times?				
How many meals did your child not eat at the kitchen or dining room table?				
How many meals were eaten at "fast food" restaurants?				

How often do the following typically occur? (check only one answer)

	Always	Usually	Sometimes	Seldom	Never
Do you allow your child to eat whenever they request food between meals?					
Do you make mealtimes fun or entertaining?					
Do you insist your child try 'one bite' of a new food?					
Do you insist your child take a bite of each food before they can leave the table?					
Do you physically put food into your child's mouth?					
Do you allow your child to choose favorite plates or utensils to eat with?					
Do you punish your child for not eating (spanking or time-out)?					
Do you insist your child 'clean his/her plate' before they leave the table?					
Do you praise your child for eating?					
Do you offer activities as a reward for eating?					
Do you give your child the option of eating foods other than those served?					
Do you send your child away from the table if he/she is not eating?					
Do you allow your child to flavor foods however he or she wants?					
Do you make your child stay at the table until all or a certain amount of food has been eaten?					
Do you restrict your child from eating certain foods without your permission?					
Do you give your child dessert for eating certain foods?					
Do you encourage your child to eat fruits and vegetables every day?					

Food Consistency: Please check all that are applicable:

Does eat	Can eat	Never tried	Can't eat
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Food consistency
Liquids/soups
Stage 1 or 2 baby food

Stage 3/junior baby food
Creamy foods
Blenderized table food
Mashed table food
Chopped table food
Regular table food
Crisp food (crackers)
Chewy food (meat)
Crunchy food (carrot)

Describe any special diet. _____

Meal Pattern

Please write down a 3-day diet history on the back of one of these pages or on another piece of paper. Include everything your child has to eat or drink, approximate amounts eaten, and what time they were eaten.

Describe a typical meal in detail (what happens when you offer food?)

Do the child's food habits and preferences match the family's? Yes No

Does the child eat little at meals and snack throughout the day? _ Yes No

Appetite is best described as: (circle one) poor fair good excellent eats too much

How long does it take for the child to complete a meal? (circle one)
 less than 10 min. 10-20 min. 20-30 min. 30-60 min. over 60 minutes

How does the child indicate hunger? _____

Does your child currently have, or has your child had, any of the following issues?

Check the appropriate box(es).

Current	Previous	Type of Issue	Current	Previous	Type of Issue
		Autism, PDD, or Asperger's			Gastroesophageal Reflux
		Developmental or Speech Delay			Chronic constipation
		ADHD			Chronic diarrhea
		Learning Disability			Food Allergies
		Mental Retardation			Lactose Intolerance
		Traumatic Brain Injury			Seasonal Allergies
		Depression or Bipolar Disorder			Blind or severe vision impairment
		Anxiety Disorder or OCD			Deaf or severe hearing impairment
		Cerebral Palsy			Delayed Gastric Emptying
		Spina Bifida			G-tube or NG-tube feeding
		Seizure Disorder			Liver disease
		Diabetes, Type I or Type II			Endocrine disorder or problems with growth
		Prematurity			Heart problems
		Kidney disease			Asthma or lung problems

Any Other Medical Condition, Developmental Problem, or Behavioral Issue:

Current Oral - Motor Status

Are there any problems or concerns with? (check all that apply)

Drooling	Poor sucking
Poor tongue control	Problems with biting
Poor lip control	Lack of chewing
Swallowing problems	Hypersensitive to temperature, texture, etc.
Teeth grinding	Sweating while eating
Coughing/gagging	Ruminating/vomiting

Were any of the following ever used ? (Please circle)

tracheotomy tube

NG tube

nasal cannula

gastrostomy tube

Current Tube Feeding Information

Type of feeding tube (please circle): G- tube J-Tube NG- tube NJ- tube

Type of formula used: _____

What is the caloric density (how many calories per ounce)? _____

What does your child receive from the tube feeding in 24-hours (please specify formula, water, etc.)?

How is feeding done?

Continuous feeding:

How much per hour _____ Time feeding run (start time/stop time) _____

Bolus feeds:

What is the bolus schedule? _____

Volume per bolus _____ How long does a bolus feed take? _____

Circle the appropriate answer:

How many times per week does your child vomit during or within one hour of tube feeding?

0 times 1-3 times 4-6 times 7-9 times 10 or more times

How much does your child typically vomit?

Less than one tablespoon About one tablespoon More than one ounce

How many times per week does your child gag or retch during or within one hour of tube feeding?

0 times 1-3 times 4-6 times 7-9 times 10 or more times

How many times per week does your child cry during or within one hour of tube feeding?

0 times 1-3 times 4-6 times 7-9 times 10 or more times

How many times per week does your child sleep through the night without awakening?

0 days 1-2 days 4-5 days 6-7 days

How often does your child experience problems with constipation?

Daily Weekly Monthly

How often does your child experience problems with diarrhea?

Daily Weekly Monthly

Have you had difficulty increasing the rate or volume of your child's tube feeding? Y N

Has your child had difficulty gaining weight on the current tube feeding schedule? Y N

Current Feeding Skills (check all that apply)

_____ drinks from bottle _____ held by caregiver _____ child holds bottle

_____ feeds self with fingers

_____ feeds self with spoon _____ with help _____ without help

_____ feeds self with fork _____ with help _____ without help

_____ drinks from open cup/glass _____ with help _____ without help

_____drinks from sippy/tippy cup _____with help _____without help

Please list:

- a. Favorite foods: _____
- b. Favorite recreational materials: _____
- c. Favorite activities: _____