We assess and provide individualized treatment for children experiencing developmental feeding delays, oral-motor deficits, and sensory-based feeding challenges. Our services are directed towards developing the skills necessary, and providing the social-emotional support, to promote a positive mealtime experience. We integrate neurodevelopmental, oral-motor, sensory and relationship-based approaches into our treatment.

Treatment of feeding disorders often requires coordination of services from a multidisciplinary team. If during the initial patient intake or assessment process, additional needs or support are identified, appropriate recommendations for services will be made.

In order to provide you with the best possible Evaluation, we need additional information regarding your child's current feeding skills, your primary concerns and any other medical information or history that will be helpful in the assessment process. The forms below are needed prior to scheduling your child's Evaluation:

Forms Requested

- ❒ Food Intake Form
- ❒ 3-Day Food Log
- ❒ Any other medical information or reports that may assist us in understanding your child's medical or feeding history (i.e. Speech Therapy, hospital reports, swallow studies etc...)

On the Day of your Childs Evaluation

- ❒ Please bring food and drink items that your child likes as well as food that they have difficulty with. It is helpful to bring a variety of textures, if applicable.
- ❒ Please bring utensils that your child uses regularly at home, such as bottle, nipple, spoon and/or fork.
- ❒ Bring your child hungry, but not uncomfortable.

When you come for your evaluation, please arrive 15 minutes early so we are able to complete any paperwork with you and obtain financial information.

Bring your insurance card (please bring all cards, if you have more than one plan). If you have any questions, please feel free to call our office at 404.933.9869.

1525 Haven Crest Drive, Powder Springs, GA 30127 | FAX 1-866-430-3367 | EMAIL charlene@betterlivingOT.com

Pediatric Feeding Intake Form

Biographical Information

Child's Name: _____ Sex: ☐ M ☐ F

Date of Birth/Age: _____ Parents Names: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Who can I thank for this referral? _____

What is your major feeding concern? Please describe feeding problem.

_____

_____

What is your feeding goal(s) for your child?

_____

_____

Name of Primary Care Physician/Pediatrician: Name of Gastroenterologist:

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Please list any other specialists who are treating your child:

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Is your child participating in an Early Intervention Program? ☐ Y ☐ N
If yes, please list therapists involved (i.e. SLP, OT, PT, nutritionist, etc.):

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Medical Information

Medical Diagnoses:

_____

_____

_____

Prenatal/Birth History

Length of pregnancy (weeks): _____

Were there any complications during pregnancy or delivery? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Pregnancy details: ☐ Full term ☐ Premature ☐ Vaginal ☐ C-Section

Complications following delivery: ☐ No ☐ Yes

_____

_____

Birth Weight_____ Current weigh/Height: _____

Hospitalization/surgical history

Date(s):_____ _____ _____ _____

Reason (s) for hospitalization:

_____

_____

Known precautions/allergies

Medical allergies: _____

Food allergies: _____

Please Circle: ☐ Current Medications ☐ Not currently taking medications

Medication 1: _____How long? _____

Prescribed for: _____

Medication 2: _____How long? _____

Prescribed for: _____

Medication 3: _____How long? _____

Prescribed for: _____

Additional Medications:

_____

_____

1525 Haven Crest Drive, Powder Springs, GA 30127 | FAX 1-866-430-3367 | EMAIL charlene@betterlivingOT.com

Gastrointestinal History/Current Gastrointestinal (GI) Concerns

Has your child ever had any of the following studies? Please attach copies of studies if you have them and/or include the physician or hospital involved on you release of information:

- Chest X-Ray Date: _____
- Videofluroscopy Date: _____
- Upper GI series Date: _____
- Endoscopy Date: _____
- Gastric Emptying Scan Date: _____
- PH study Date: _____
- Allergy Studies Date: _____

HISTORY of Reflux/ GERD? ○ Yes ☐ No

If yes, check all that apply:

- ☐ Spitting up
- ☐ Arching
- ☐ Failure to thrive
- ☐ Burping
- ☐ Coughing
- ☐ Seeming desire to eat then refuses
- ☐ Slow gastric emptying
- ☐ Vomiting
- ☐ Drooling
- ☐ Chronic diarrhea
- ☐ Constipation
- ☐ Dehydration
- ☐ General discomfort when eating

Please provide additional notes: _____

HISTORY of GI surgery: ☐ Yes ☐ No

If yes, please explain: _____

Did your child ever receive any alternative feeds? ☐ Yes ☐ No

If yes, please select (all that apply):

- ☐ NG-tube
- ☐ G-tube
- ☐ J-tube
- ☐ TPN Other: _____

Type of feeding received: ☐ Bolus Continuous ☐ Combination Other

Please Describe Feeding Schedule

_____

_____

ENT: (Please circle any that apply.

- ○ Ear Infections
- ○ Aspiration
- ○ Bronchitis
- ○ Upper Respiratory Infections
- ○ Pneumonia
- ○ Coughing /choking episodes when eating.

Bowel Habits: Frequency of Bowel Movements _____ times per ☐ day ☐ week (circle one).

Consistency: (hard, soft,) _____

Feeding History: Breast Fed ☐ No ☐ Yes If yes, at what age was your child weaned? NA/Age _____

Bottle fed: ☐ No ☐ Yes Breast milk/Formula? Current formula: _____

Formula type: Powder/Concentrate/Ready-to-feed. _____

_____

List any previous formulas & describe tolerance: _____

_____

Other fluids presented in bottle: _____

Solids: at what age were cereals/ baby foods introduced? _____

_____

Please circle the Stages of baby food that your child ate/eats: ☐ 1st ☐ 2nd ☐ 3rd ☐ Toddler ☐ DICED

Any problems? _____

Does your child have any of the following? Please indicate when problem started.

Food Refusal (refusing all or most foods). Age started: _____

Food Selectivity by texture (eating only textures that are NOT age appropriate) Age started: _____

Food Selectivity by Type (eating a limited variety of foods). Age started: _____

Food Selectivity by Smell or Touch. Age started: _____

Oral motor delays (problems with chewing, etc.). Age started: _____

Dysphagia (problems with swallowing/coughing choking). Age started: _____

Abnormal preferences (temperature sensitive, color specific, particular brands). Please describe: _____

_____

Other feeding problems: _____

Current Meal Pattern

Which meal is your child's best? _____

Worst? _____ How long does a 'typical' meal take? _____

Please List preferred foods: _____

_____

_____

Please list non-preferred foods: _____

_____

_____

Please indicate your child's typical meal schedule. Number/Timing of meals/snacks: _____

_____

_____

1525 Haven Crest Drive, Powder Springs, GA 30127 | FAX 1-866-430-3367 | EMAIL charlene@betterlivingOT.com

Describe sequence in which food/liquids are offered (i.e. liquids first): _____

_____

Feeding Behavior Does your child experience any of the following with feeding?

- ☐ Hypersensitive
- ☐ Sweating
- ☐ Chewing
- ☐ Coughing
- ☐ Problem with biting
- ☐ Gagging
- ☐ Vomiting
- ☐ Hx of: Aspiration/Penetration
- ☐ Choking
- ☐ Drooling
- ☐ Overstuffs mouth
- ☐ Teeth Grinding

Other_____

Feeding Behavior Does your child exhibit any of these behaviors at mealtimes?

N/Y Circle all that apply.

- ☐ Cries or screams
- ☐ Throws food
- ☐ Pushes food away
- ☐ Leaves table
- ☐ Clenches lips
- ☐ Messy
- ☐ Eats too fast/slow Leaves table
- ☐ Wants 'down
- ☐ Shuts Down
- ☐ Refuses to Self-feed
- ☐ Plays with food
- ☐ Refuses to swallow
- ☐ Refuses to open mouth
- ☐ Spits food out
- ☐ Picky Eater
- ☐ Induces Vomiting
- ☐ Eats non-food items
- ☐ Refuses to self-feed

Refuses to touch certain foods

Other: _____

Where does your child currently eat (circle all that apply)

☐ Adult's Lap ☐ Infant seat ☐ High chair ☐ Booster Chair ☐ Sofa ☐ Crib/Bed

☐ Car seat ☐ Modified Chair ☐ Wheel chair ☐ Tumble form ☐ Roaming- Kitchen/other rooms in the house

Other: _____

What feeding techniques do you use with your child to get him/her to eat? _____

_____

_____

What does your child drink from (circle please): ☐ Bottle ☐ Sippy Cup ☐ Open Cup ☐ Straw

Is your child able to self-feed? ☐ Yes ☐ No

_____ _____

Signature Date

I look forward to meeting you and your child.

1525 Haven Crest Drive, Powder Springs, GA 30127 | FAX 1-866-430-3367 | EMAIL charlene@betterlivingOT.com

Feeding Record: Day 1

Day 1 Date	Child's Name	Present Height
	Date of Birth	Present Weight

Please fill out for three days. Include all foods and liquids taken orally and, if applicable, also include gastrostomy (GT) feedings**.** Be sure to **list ALL parts of each meal** as described in directions**.** Indicate if **fed by self, or caregiver**, and **any adaptations.**

TIME OF DAY OFFERED *How Long did it take to eat?*	FOOD OFFERED	AMOUNT OF FOOD EATEN	OFFERED BY

Feeding Record: Day 2

Day 2 Date	Child's Name	Present Height
	Date of Birth	Present Weight

Please fill out for three days. Include all foods and liquids taken orally and, if applicable, also include gastrostomy (GT) feedings**.** Be sure to **list ALL parts of each meal** as described in directions**.** Indicate if **fed by self, or caregiver**, and **any adaptations.**

TIME OF DAY OFFERED *How Long did it take to eat?*	FOOD OFFERED	AMOUNT OF FOOD EATEN	OFFERED BY

Feeding Record: Day 3

Day 3 Date	Child's Name	Present Height
	Date of Birth	Present Weight

Please fill out for three days. Include all foods and liquids taken orally and, if applicable, also include gastrostomy (GT) feedings**.** Be sure to **list ALL parts of each meal** as described in directions**.** Indicate if **fed by self, or caregiver**, and **any adaptations.**

TIME OF DAY OFFERED *How Long did it take to eat?*	FOOD OFFERED	AMOUNT OF FOOD EATEN	OFFERED BY