

### Feeding/Eating History Form

Patient Name:	DOB:	Today's Date:
Name of person completing form:	Relationship to Patient:	

**Instructions: Place a check beside any area that applies to your child**

**What is the purpose of the evaluation:**

- Does not like putting things in or near mouth
- Refusing food
- Difficulty transitioning to solids
- Choking and/or coughing when eating
- Gagging or vomiting when eating
- Difficulty accepting liquids by mouth
- Difficulty accepting solids by mouth
- Reduced variety of foods
- Reduced volume of foods
- Follow up to a swallow study (MBS or FEES)
- Nutrition concerns
- Poor weight gain
- Failure to thrive
- Other \_\_\_\_\_

**Allergies/Intolerances to any food, environmental, any other?**

- None
- Yes, \_\_\_\_\_

**Medical History related to feeding/eating:**

- Esophageal Reflux
- Nasal Reflux
- Upper GI Testing Done –results \_\_\_\_\_
- Modified Barium Swallow Study (MBS)  
Date of most recent MBS \_\_\_/\_\_\_/\_\_\_  
Results \_\_\_\_\_
- Fiberoptic Endoscopic Evaluation of Swallowing, (FEES)  
Date of most recent FEES \_\_\_/\_\_\_/\_\_\_  
Results \_\_\_\_\_
- Constipation \_\_\_\_\_
- Diarrhea/Loose Stools \_\_\_\_\_
- Asthma \_\_\_\_\_
- Respiratory Status: \_\_\_\_\_
- Cardiac Status: \_\_\_\_\_
- See additional history \_\_\_\_\_
- Related/Previous therapy services \_\_\_\_\_

**IN THE PAST**

**How has your child taken food in the PAST?**

- By mouth
- By mouth and tube (NG, NJ, GJ, GT, OG, OJ),
- By tube (NG, NJ, GJ, GT, OG, OJ),
- Other \_\_\_\_\_

**Has your child had any feeding difficulties in the PAST?**

- Difficulties with Breast feeding?
- With transitions to foods?
- Controlling liquids in the mouth?
- Managing or accepting solids?
- Family History of feeding problems, intolerances or allergies: Please list: \_\_\_\_\_

**CURRENTLY**

**How does your child take in food NOW?**

- By mouth
- By mouth and tube (NG, NJ, GJ, GT, OG, OJ),
- By tube (NG, NJ, GJ, GT, OG, OJ),
- Other \_\_\_\_\_

**Is your child having any difficulties with the following?**

- Difficulties with Breast feeding?  With transitions to foods?
- Controlling liquids in the mouth?
- Managing or accepting solids?
- When is your child fed/ or eat by MOUTH?**
- Ad lib
- \_\_\_\_\_ times a day
- Every \_\_\_\_\_ hours
- Other \_\_\_\_\_

How long does it take to eat a meal? \_\_\_\_\_

**When is your child fed by TUBE:**

- Ad lib
- Continuous (rate \_\_\_\_\_ for how long \_\_\_\_\_)
- Bolus (every \_\_\_ hours, volume \_\_\_\_\_, Frequency \_\_\_\_\_, Length of Feeding \_\_\_\_\_, Pump or syringe (gravity)
- Other \_\_\_\_\_

How long does it take to deliver each feeding? \_\_\_\_\_

PATIENT NAME:	DOB:	Today's Date:
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**Current diet:**

**Liquids**

Formula (type) \_\_\_\_\_  Breast milk  Cow's milk

Soy Milk

Other liquids \_\_\_\_\_

Quantity of liquid per day \_\_\_\_\_ ounces

**Solids:** Types/quantities of food eaten for meals:  Not developmentally appropriate.

**Breakfast:** \_\_\_\_\_

\_\_\_\_\_

**Lunch:** \_\_\_\_\_

\_\_\_\_\_

**Snacks:** \_\_\_\_\_

\_\_\_\_\_

**Dinner:** \_\_\_\_\_

\_\_\_\_\_

**Other foods your child has tried 1-2 times before but does not regularly eat:** \_\_\_\_\_

\_\_\_\_\_

<p><b>Eating Routine:</b></p> <p><input type="checkbox"/> Does your child eat in a High Chair?</p> <p><input type="checkbox"/> Does your child eat in a Car Seat?</p> <p><input type="checkbox"/> Does your child eat at the Table?</p> <p><input type="checkbox"/> Does your child eat at the counter/bar?</p> <p><input type="checkbox"/> Does your child eat with other family members present?</p> <p><input type="checkbox"/> Do you use distraction? List types _____</p>	<p><b>Reported Self Feeding Skills:</b></p> <p><input type="checkbox"/> Bottle (6+ months)</p> <p><input type="checkbox"/> Fingers (14-16 months)</p> <p><input type="checkbox"/> Spoon( 14-30 months)</p> <p><input type="checkbox"/> Fork (14-36 months)</p> <p><input type="checkbox"/> Sippy Cup</p> <p><input type="checkbox"/> Open Cup</p> <p><input type="checkbox"/> Straw</p> <p><b>Other</b></p>
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**Comments:**

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY OF ALLERGIES:**

\_\_\_\_\_

\_\_\_\_\_

**CHILD'S ALLERGIES:**

\_\_\_\_\_

\_\_\_\_\_

**EATING CONCERN'S:**

\_\_\_\_\_

\_\_\_\_\_

Please list the foods your child will eat from each category:

Meats/Eggs/Cheese	Carbohydrates: Cereal/bread/cookies/cracker Chips/rice/potatoes	Fruits	Vegetables

Please list the foods your child **AVOIDS** from each category:

Meats/Eggs/Cheese	Carbohydrates: Cereal/bread/cookies/cracker Chips/rice/potatoes	Fruits	Vegetables

High Allergy Foods Y/N	Avoided Textures:	Snacks:	Foods you DO NOT want your child to have:
Honey            Y   N			
Peanut Butter   Y   N			
Tree Nuts        Y   N			
Citrus Fruits    Y   N			
Acidic Foods    Y   N			
Corn              Y   N			
Eggs              Y   N			
Whole Milk      Y   N			
Wheat            Y   N			
Hot Dogs         Y   N			

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ PAN# \_\_\_\_\_  
Food Allergies: \_\_\_\_\_

**Feeding Checklist**

**PLEASE MARK ONLY THE FOODS THAT YOUR CHILD EATS REGULARLY:**

**Texture Preferences**

- Crunchy
- Crisp
- Smooth
- Lumpy
- Uniform lumpy (i.e. cottage cheese)
- Hard
- Chewy
- Mixed Consistencies

**Taste Preferences**

- Salty
- Sweet
- Spicy
- Tart
- Flavored
- Bland

**Temperature Preferences**

- Hot
- Warm
- Cold
- Cool

**Appetite**

Best time of day to eat \_\_\_\_\_

**Overall description of appetite**

- Poor
- Fair
- Good
- Varies from day to day

Selective Eating Age of Onset: \_\_\_\_\_

Current # Accepted Foods: \_\_\_\_\_

Current # Accepted Liquids: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ PAN# \_\_\_\_\_

Food Allergies: \_\_\_\_\_

**Breads**

- Crackers
- Chips
- Pretzels
- Snack mix
- Bugles
- Cheese puffs
- Tostitos/taco chips
- Taco shells (hard)
- Flour tortillas
- Rolls
- Pizza crusts
- Hamburger or hot dog buns
- Bread (white, wheat, rye, potato, rice, gluten-free, pumpnickel, bagels, French bread)
- Plain bread sticks
- Garlic bread sticks
- Texas toast/garlic bread
- Hot rolls, baked bread, crescent rolls, croissants
- Biscuits
- Doughnuts, sweet rolls, cinnamon rolls, caramel rolls
- Banana bread, pumpkin bread, apple bread; muffins
- Corn bread
- Cupcakes
- Cake, pies, pastries
- Cheesecake
- Cookies

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ PAN# \_\_\_\_\_

Food Allergies: \_\_\_\_\_

**Meats**

- Baked chicken
- Fried chicken
- Chicken strips
- Chicken nuggets
- Turkey
- Poultry
- Fish (fried)
- Fish (baked or broiled)
- Tuna
- Salmon
- Beef (steak, roast, deli-style)
- Roast
- Ribs
- Deer
- Hamburger
- Steak
- Ham
- Veal
- Pork
- Sausage
- Bacon
- Chicken or ham salad
- Tuna salad
- Meatballs
- Hot dogs
- Corn dogs
- Bologna
- Lunch meat
- Lil' smokies
- Baby food meat sticks
- Baby food meats (what types? \_\_\_\_\_)

**Nuts**

- Peanut butter. Specific brands? \_\_\_\_\_
- Peanuts
- Walnuts
- Cashews
- Pecans

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ PAN# \_\_\_\_\_  
Food Allergies: \_\_\_\_\_

**Potato Products**

- French fries
- Tater tots
- Tater rounds
- Hash browns
- Fried potatoes
- Baked potatoes
- Potato chips
- Potato wedges
- Shoestring potato sticks
- Mashed potatoes
- Mashed potatoes with butter
- Mashed potatoes with gravy
- Scalloped/au gratin potatoes
- Baked sweet potatoes
- Sweet potato chips
- Sweet potato fries
- Vegetable chips

Other: \_\_\_\_\_

**Condiments**

- Ketchup
- Mayonnaise
- Miracle Whip
- Mustard
- Dijon or spicy mustard
- Honey mustard
- BBQ sauce
- A1 Steak Sauce
- Chili sauce
- Worcestershire sauce
- Ranch dressing

Other salad dressings:

\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ PAN# \_\_\_\_\_  
Food Allergies: \_\_\_\_\_

**Breakfast Foods**

- Oatmeal
- Cream of Wheat
- Pop-Tarts (frosted or plain)
- Dry cereals
- Pancakes
  - with fruit
  - with syrup
- Waffles (homemade)
- Waffles (frozen)
- French toast
- Eggs
  - scrambled
  - omelet
  - fried
  - boiled
  - poached
  - with cheese, vegetables, salsa, chopped meats, etc.
- Toast
  - with cinnamon and butter
  - with jelly
  - with apple butter
  - with peanut butter
  - with honey (after age two)
- Breakfast shakes
- Yogurt
- Go-Gurt (what types? \_\_\_\_\_)
- Fresh fruit
- Grits

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ PAN# \_\_\_\_\_  
Food Allergies: \_\_\_\_\_

**Vegetables**

- Green beans
- Broccoli
- Cauliflower
- Corn
- Squash
- Cucumber
- Zucchini
- Spinach
- Carrots
- Lettuce
- Coleslaw
- Cabbage
- Sweet potatoes
- Tomatoes
- Asparagus
- Brussels sprouts
- Green pepper
- Onion
- Peas
- Salsa
- Vegetable baby food (what types?)

\_\_\_\_\_  
\_\_\_\_\_) )  
Other: \_\_\_\_\_

**Liquids**

- Juice (Circle all that apply): orange, cherry, berry, grape, fruit punch, strawberry, strawberry kiwi, cranberry fruit cocktail, white grape, pear, or other: \_\_\_\_\_
- Lemonade
- Milk (circle all that apply): whole, 2 percent, skim
- Flavored milk (what types?)

\_\_\_\_\_) )  
 Soda (circle all that apply): cola, lemon lime, orange, grape, root beer, cream soda.  
Specific brands: \_\_\_\_\_

- Tea (circle all that apply): sweetened, unsweetened
- Milk shakes
- Floats
- Drinkable yogurt
- Water
- Caloric supplements (chocolate, vanilla, strawberry, banana cream)

Other: \_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ PAN# \_\_\_\_\_  
Food Allergies: \_\_\_\_\_

**Fruits**

- Apple
- Banana
- Blueberry
- Cantaloupe
- Cherry
- Grapes
- Kiwi
- Lemon
- Lime
- Orange
- Pear
- Pumpkin
- Watermelon
- Raisin
- Raspberry
- Rhubarb
- Strawberry
- Tangerine
- Tomato
- Dried fruit

**Pasta/Italian-style dishes**

- Spaghetti
- Lasagna
- SpaghettiOs/Ravioli's
- Casseroles (e.g., Hamburger Helper)
- Rice dishes: \_\_\_\_\_
- Noodle dishes: \_\_\_\_\_
- Couscous
- Pizza
- Pizza Toppings: \_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ PAN# \_\_\_\_\_

Food Allergies: \_\_\_\_\_

**Soups**

- Cheese
- Cheese and broccoli
- Cheese and vegetables
- Chili
- Stew
- Vegetable
- Vegetable beef
- French onion
- Egg drop
- Beef noodle
- Chicken noodle
- Chicken and rice
- Other: \_\_\_\_\_

**Cheese/Dairy**

- Cheddar
- American
- Parmesan
- Swiss
- Monterey Jack
- Mozzarella
- Colby
- Cottage cheese
- Sour cream
- Yogurt (what types? \_\_\_\_\_)
- Cool whip
- Whipped cream
- Ice cream (what types? \_\_\_\_\_)
- Sherbet (what types? \_\_\_\_\_)

**Fast Foods:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ PAN# \_\_\_\_\_  
Food Allergies: \_\_\_\_\_

***We also analyze favorite and least favorite foods for patterns and similarities.***

**Please list your child's favorite foods/liquids:**

- 1.
- 2.
- 3.
- 4.
- 5.

**Please list your child's least favorite foods/liquids:**

- 1.
- 2.
- 3.
- 4.
- 5.

**What goal foods would you like to see your child eat with the rest of the family?**

- 1.
- 2.
- 3.
- 4.
- 5.

**Are there times when your child eats well?**

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**Is your child taking any medications?**

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**Comments:**

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