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Feeding Therapy Intake Form

I. BIOGRAPHICAL

Patient Name			
Patient DOB		Patient SSN	

Has your child been treated before at Bloom: **YES NO**

II. FEEDING DIFFICULTY

Please list feeding issues that are causing problems.

Description of Behavior	When it started

III. PAST THERAPEUTIC PROCEDURES TO ADDRESS FEEDING ISSUES

Please list your child's past and current therapies for feeding difficulties.

Physician or Clinician	Type of Therapeutic Intervention	Phone Number

Has your child had any recent procedures/surgeries? **YES** **NO**

If yes what? ____

Please check if your child has had the tests below:

- ☐ **Swallow study (MBS/OPMS)** **Date:** ____________ **Result:** ____________
- ☐ **Endoscopy** **Date:** ____________ **Result:** ____________
- ☐ **Gastric Emptying** **Date:** ____________ **Result:** ____________
- ☐ **pH Probe** **Date:** ____________ **Result:** ____________
- ☐ **Upper GI** **Date:** ____________ **Result:** ____________
- ☐ **Allergy Testing** **Date:** ____________ **Result:** ____________
- ☐ **Skin Test** **Date:** ____________ **Result:** ____________
- ☐ **Blood Test** **Date:** ____________ **Result:** ____________

Has your child ever been administered a feeding tube? **YES** **NO**

If so, when and why? ____

Bowel Habits:

Frequency of Bowel Movement: ____________times per (circle one): **DAY** **WEEK**

Consistency: **HARD** **SOFT** **LOOSE** **WATERY**

IV. CURRENT FEEDING PRACTICES

Please check all skills that apply

a. How is the child positioned for feeding?

- ☐ chair at table
- ☐ booster seat
- ☐ high chair
- ☐ reclined
- ☐ adaptive chair, type:____________
- ☐ Other:____________

b. ________Drinks from bottle

- ☐ child holds bottle
- ☐ adaptive bottle
- ☐ nipple used____________

c. ________Fed by parents

d. ________ Feeds self with fingers Large pieces ________ Small pieces ________

e. ________ Feeds self with spoon Adaptation utensil________ Independent________

f. ________ Feeds self with fork Independent________

g. ________Uses Knife Spreads________ Cuts__________

h. ________Drinks from cup/glass Special adaptation device_________

i._________Drinks from straw

j._________Pours own drink

k._________Has child *ever* self fed?

Where does your child currently eat?

Adult's Lap		Booster Seat		Infant Seat		Table/Chair		High Chair		Standing/Walking	
Other:											

Food consistency: Please check all that are currently applicable:

Consistency Type	Does Eat	Can Eat	Never Eats	Can't Eat	Has Not Tried
Liquid/soups					
Strained Baby Food					
Junior Baby Food					
Creamy Foods					
Blended Food					
Mashed Food					
Chopped Food					
Regular Table Food					
Crispy Food					
Crunchy Food					
Chewy Food					

List foods consistently accepted:

Fruits	
Vegetables	
Meats	
Dairy	
Breads/Cereals	
Grains	
Other	

Special Diets:

- ☐ **Kosher**
- ☐ **Gluten Free**
- ☐ **Casein Free**
- ☐ **GFCF**
- ☐ **Vegetarian**
- ☐ **Vegan**

V. BEHAVIORAL CONCERNS REGARDING FEEDING

Does your child exhibit behavior problems during mealtimes? **YES** **NO**

Check all behaviors that are problematic during mealtime:

	Throws food		**Takes food from others**
	Spits food		**Aggressive toward others present at table**
	Cries, screams		**Refuses food**
	Elopes from table		**Overeats**
	Only eats specific foods		**Consumes too fast**
	Pushes over table or chair		**Hits self**
	Throws utensils or other dinner ware		**Scratches self**
	Messy eater		**Bites self**

What do you do when your child has behavior problems at mealtime? ______________________________

____

VI.

MEAL PATTERNS

Please list your child's typical mealtime schedule and sample meals. Give approximate amounts.

Sample/Typical Meal		**Approximate Time**
Morning		
Afternoon		
Evening		
Snacks		

Describe the sequence in which food is offered to your child (e.g., liquids always first, etc.):

____

Do your child's habits and preferences match any family member's habits? **YES** **NO**

If yes, who and what habit or preference ______________________________

____

Does your child eat little meals and snacks throughout the day? **YES** **NO**

Your child's appetite is best described as (circle one):

POOR **FAIR** **GOOD** **EXCELLENT** **OVER EATS**

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

less than 10 minutes **10-20 minutes** **20-30 minutes** **over 60 minutes**

How does your child indicate hunger?____

What do you do when your child refuses to eat/drink?____________________________________

____

Please list any secondary concerns regarding your child's eating habits:

____

____

____

What do you hope to attain from therapeutic interventions?

____

____

____

Thank you for completing the feeding profile. Once the profile is reviewed, physical hindrances are ruled out, and behavioral functions are determined, dietary goals will be developed by a team of clinicians, including a dietitian. Feeding goals are based upon current acceptance, nutritional need, and physical abilities. Please complete the food log on the following pages for your clinical team to determine a baseline of data.

4 Day Food Log

Instructions: Record all food/ fluid consumed during the next four days. Please be as specific as possible to ensure accuracy of the analysis. Include brand names and methods of preparation if appropriate.

Date:	Food Item:	Amount:	Brand:
Date:	**Food Item:**	**Amount:**	**Brand:**

Date:	Food Item:	Amount:	Brand:
Date:	**Food Item:**	**Amount:**	**Brand:**

Notes: