Child's name: *

First Name Last Name

Parent 1 name: *

First Name Last Name

Parent 1 email: *

example@example.com

Parent 2 name: *

First Name Last Name

Parent 2 email:

example@example.com

Date of birth: *

Current age:

Please list any medical diagnoses

Pediatrician name, practice name, and location: *

Do you prefer a copy of the written evaluation to be provided to your child's pediatrician? *

- ○ Yes
- ○ No

Birth/Medical History

Birth history: *

- ☐ Full Term
- ☐ Premature
- ☐ Adopted
- ☐ Delivered Vaginally
- ☐ Delivered by C-Section
- ☐ Multiple Birth
- ☐ Breech Birth
- ☐ NICU / Complications at birth

Additional birth history information:

Other medical history:

Hospitalizations/surgeries/ procedures:

(Including X-ray, MRI, CT scan, genetic testing, blood work-ups, Modified Barium Swallow Study, G-Tube)

Precautions and any additional Information we should be aware of:

(Please list above)

Medications:

Please list any allergies:

Current Feeding

GI: (please check all that apply) *

- ☐ Reflux
- ☐ Constipation
- ☐ Dehydration
- ☐ Nausea
- ☐ Chronic diarrhea
- ☐ Inability to gain weight
- ☐ Vomitting
- ☐ None of the above

Respiratory: (please check all that apply) *

- [ ] Chronic colds
- [ ] Wheezing
- [ ] Asthma
- [ ] Aspiration
- [ ] Choking
- [ ] Pneumonia
- [ ] Hoarse voice
- [ ] None of the above

Behaviors observed during feeding: (please check all that apply) *

- [ ] Choking
- [ ] Gagging
- [ ] Crying
- [ ] Coughing while eating or drinking
- [ ] Eyes water after liquid intake
- [ ] Difficulty swallowing/breathing
- [ ] Reflux
- [ ] Tires easily
- [ ] Poor appetite
- [ ] Chews, but does not swallow
- [ ] Spits food purposefully
- [ ] Refuses bites offered because of texture or smell
- [ ] Gurgly voice
- [ ] Vomiting during/after feeding
- [ ] Leaves the table
- [ ] Loss of food out of oral cavity
- [ ] Swallows food without chewing
- [ ] Overstuffs mouth with food
- [ ] Pockets food in cheeks
- [ ] Food remains in mouth after mealtime is over
- [ ] None of the above

Typical mealtimes: *

Please list the types of liquid your child consumes: *

Please list the foods your child consumes: *

Please list the types of foods your child avoids: *

Please check the methods of consumption your child has used/currently using: *

- ☐ Breast
- ☐ Bottle
- ☐ Sippy cup
- ☐ Straw
- ☐ Open cup
- ☐ Other

For the methods selected, describe the age at which they were used and when the method was discontinued (if applicable). Please comment on your child's current preferred method of intake. *

Please check the methods of consumption your child has used/currently using: *

- [ ] Spoon (by caregiver)
- [ ] Fingers (by caregiver)
- [ ] Fork/Spoon (self)
- [ ] Fingers (self)
- [ ] Other

For the methods selected, describe the age at which they were used and when the method was discontinued (if applicable). Please comment on your child's current preferred method of intake. *

Check All That Apply *

- [ ] Child eats at same time and place with family
- [ ] Child helps with meal set up or clean up
- [ ] Child accompanies you to the grocery store
- [ ] Child stays seated during mealtime
- [ ] Child leaves table when finished eating (even when family is still eating)
- [ ] Child eats different meals than others at mealtime
- [ ] Meals are often eaten at school, at a restaurant or on-the-go
- [ ] Mealtimes require a distraction (ie. TV, Ipad)
- [ ] Child is rewarded after completing meals
- [ ] Child no longer eats food that they once accepted
- [ ] None of the above

Please state any additional information you would like to share with us about your child's feeding.