Atlantic Beach, FL 32233
(904) 647-1849

Feeding Therapy Intake Form

I. BIOGRAPHICAL

Patient Name			
Patient DOB		**Date of last dental visit:**	
Is there any concern regarding dental health?			

How was your child fed from infancy?

Breast Bottle Fed Both

What age was your child weaned from bottle/breast: _____ months

What age was your child introduced to solids? _____ months

What type of solid was initially presented?

Puree whole fruit whole vegetable animal protein Dairy product Cereal

Rice product Other:_____

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?

_____

_____

_____

ARFID (Avoidant Restrictive Feeding Intake Disorder) Sensitivity Scale:

Sense	Questions
Taste	Was it difficult to introduce first tastes? YES NO Does your child notice small taste changes? YES NO Does your child grimace when tasting new foods? YES NO Does your child comment on the taste of food? YES NO
Smell Sensitivity	Is your child disgusted by smells? YES NO Does your child dislike being in the kitchen or in bathrooms? YES NO Does your child dislike eating with others? YES NO
Tactile Sensitivity	Did your child gag on the first textured foods and reject them thereafter? YES NO Did your child exhibit mouthing behavior in the first year of life? YES NO Does your child dislike having messy hands and face? YES NO Does your child accept limited range in food textures? YES NO Does your child harbor food in their mouth? YES NO Does your child dislike having their teeth cleaned? YES NO
Visual Hypersensitivity	Does your child reject foods on sight? YES NO Does your child focus on small details? YES NO Does your child notice small changes in packaging? YES NO Is your child bothered by bright lights? YES NO
Auditory Sensitivity	Is your child distressed by loud noises? YES NO Does your child get upset in noisy places? YES NO Does your child dislike the sound of eating? YES NO
Interception	Does your child show that they are hungry? YES NO Do they recognize when they are hot or cold? YES NO Do you know when they are in pain? YES NO Do they recognize when they are going to have a bowel movement? YES NO
Comments	

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: