Atlantic Beach, FL 32233
Jacksonville, FL 32256
(904) 647-1849

Feeding Therapy Intake Form

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

How was your child fed from infancy?

Breast **Bottle Fed** **Both**

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

What age was your child introduced to solids? _____

What type of solid was initially presented?

Puree **mashed** **whole (baby led weaning)** **Cereal Rice product**

Other:_____

Does your child drink dairy milk with meals or in between meals? **Yes** **No**

If yes, please list the fat percentage and the approximate amount of ounces: _____

Does your child indicate that they are hungry? **Yes** **No**

If yes, please check all applicable forms of communication:

Vocally speaks **Pulls caregiver to food items** **ASL** **AAAC device** **PECS**

Other: _____

FEEDING DIFFICULTY

Please list feeding issues that are causing problems.

grazing/wandering tantrums throwing food pushing food away packing (stuffing mouth)
Pocketing (harboring food in mouth) eats too fast swiping food from plate or table

PAST THERAPEUTIC PROCEDURES TO ADDRESS FEEDING ISSUES

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

Provider or Practice	Type of Therapeutic Intervention	Phone Number

Has your child had any surgeries? **YES** **NO**

If yes what/when? _____

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**

CURRENT FEEDING PRACTICES

Where/how does your child typically eat their meals (please select all applicable options):

At table with family members **In a highchair** **Wanders**

Other: _____

Does your child exhibit any texture aversions? **Yes** **No**
If yes, please check all that apply:

Creamy textures **Crunchy textures** **Wet textures**

Other: _____

List foods consistently accepted:

Fruits	
Vegetables	
Meats	
Dairy	
Breads/Cereals	
Grains	
Other	

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**

Special Dietary Considerations:

Kosher **Vegetarian** **Vegan** **Gluten free** **GCF**

Other: _____

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**

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

_____

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 submitting the feeding intake form. After a feeding specialist reviews it and identifies a potential benefit from feeding intervention for the child, you will receive a call to arrange an initial evaluation. In certain situations, a physician may need to see the child before the evaluation to rule out any physiological concerns. This could involve procedures such as bloodwork or swallow studies, among others. We appreciate you choosing Bloom to address your child's selective eating challenges. The opportunity is truly appreciated.