STONES WORTH STEPPING, P.C.

PEDIATRIC PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY

Feeding & Swallowing Therapy Intake Form – Toddlers & Children

Name: _____

Parent's/Caregiver's Names: _____

Date of Birth: _____ Age: _____

Who Referred You: _____

Feeding Concerns

1. Why were you referred for feeding therapy/What is your primary concern?

2. What is your goal for feeding therapy?

3. What signs of feeding difficulty does your child exhibit? Please circle.

- ☐ Coughing
- ☐ Choking
- ☐ Gagging
- ☐ Watery Eyes
- ☐ Vomiting
- ☐ Drooling
- ☐ Does Not Chew Food
- ☐ Poor Breath Quality After Eating (e.g., hoarse)
- ☐ Overstuffs Mouth
- ☐ Grinds Teeth
- ☐ Cries
- ☐ Screams
- ☐ Runs Away from Table
- ☐ Picky Eater
- ☐ Turns Head Away from Utensils
- ☐ Chews Food and Spits Out
- ☐ Other: _____

Medical History

1. Medical diagnosis: _____

2. Please circle if your child has a history of any of the following medical conditions.

- ☐ Dysphagia
- ☐ Seizures
- ☐ Reflux/GERD
- ☐ Failure to Thrive
- ☐ Frequent Ear Infections
- ☐ Pneumonia
- ☐ Respiratory Illnesses
- ☐ Eczema
- ☐ Frequent Skin Rashes
- ☐ Frequent Strep Throat
- ☐ Dehydration
- ☐ Constipation

3. Medications

Name	Dose	Administration Schedule	Start Date
1. Multivitamin			
2.			
3.			
4.			

4. Hospitalizations/Surgeries

Reason for Hospitalization	Hospital	Date Admitted	Date Discharged
1.			
2.			
3.			

5. Procedures

Procedure	Date	Results
Swallow Study (MBSS)		
Gastric Emptying pH probe		
Upper GI		
Allergy Testing		
Fiber optic Endoscopic Evaluation of Swallowing (FEES)		

6. Growth/Development based on most recent medical appointment

Measurements	Percentile
Height:	
Weight:	

7. How often does your child have a bowel movement? _____

Does your child experience constipation? ◯Yes ◯No

Does your child experience loose stools? ◯Yes ◯No

Typical consistency of stools: _____

Mucous? ◯Yes ◯No Blood? ◯Yes ◯No

Developmental Feeding History

1. Milestones

Milestone	Age Completed
Drank from Sippy Cup	
Drank from Open Cup	
Drank from a Straw	
Self-Fed with Spoon	
Self-Fed with Fork	
Utilized Knife to Cut Foods	

2. Was your child breastfed? ◯Yes ◯No
If yes, please answer the following:

a. Are you currently breastfeeding? ◯Yes ◯No

b. Did you supplement with formula? ◯Yes ◯No

c. Did you experience any difficulties with breastfeeding? ◯Yes ◯No
If yes, describe:

3. Was your child bottle-fed? ◯Yes ◯No
If yes, please answer the following:

Was your child bottle-fed?

a. Are you currently bottle-feeding? ◯Yes ◯No

b. Type of Formula: _____

c. Type of Bottle/Nipple: _____

d. Did you experience any difficulties with bottle feeding? ◯Yes ◯No
If yes, describe:
_____

4. Food Introduction

Type	Age Introduced	Any Problems?
Stage 1 Baby Food		
Stage 2 Baby Food		
Stage 3 Baby Food		
Solids		
Table Foods		

Medical/ Therapy Services

1. Past Therapy Services (early intervention, PT, OT, speech, feeding, etc.)

Type of Service	Provider Name/Facility	Start Date	End Date

2. Current Therapy Services (early intervention, PT, OT, speech, feeding, etc.)

Type of Service	Provider Name/Facility	Start Date	End Date

3. Medical Services

Type of Service	Provider Name/Facility	Phone Number	Fax Number
Pediatrician/Primary Care Provider			
Gastroenterologist			
ENT			
Nutritionist			
Pulmonologist			

***Note:** Please fill out authorization of release form for providers you wish for your feeding therapist to be in communication with.

Mealtimes

1. Feeding Schedule

Meal	Time of Day	Where (home, school, daycare, etc.)	Who Assists the Child
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			

2. How long do mealtimes last? _____

3. How long do snacks last? _____

4. What is your child's best meal? _____ Worst? _____

5. Where does your child eat the best (e.g., home, daycare, etc.)? _____

6. Does your child respond better to a particular feeder? _____

7. How does your child express hunger? _____

8. Please circle which of the following seating devices your child uses during mealtimes:

- ☐ High Chair
- ☐ Seated on Parent's/Caregiver's Lap
- ☐ Booster Seat
- ☐ Table/Chair
- ☐ Seated on Floor
- ☐ Seated on Sofa
- ☐ Will Not Remain Seated
- ☐ Grazes/Roams Around Kitchen
- ☐ Wheelchair
- ☐ Crib/Bed
- ☐ Other: _____

9. Please circle what you utilize to try to increase mealtime success:

- ☐ Positive Praise
- ☐ Threats (e.g., no dessert, take away toys)
- ☐ Distractions with Toys
- ☐ Distractions with Electronics
- ☐ Ignore
- ☐ Provide a Separate Meal
- ☐ Model
- ☐ Rewards
- ☐ Sticker Charts
- ☐ Time Out

Other Important Information

_____ _____

Signature/Relationship to Child **Date**