COURAGE KENNY REHABILITATION INSTITUTE™

Pediatric Patient Feeding
INTAKE FORM

Patient Name: _____

Parent/Legal Guardian Name: _____

Person Completing Form: _____ Relationship to patient: _____

Please answer the following questions to the best of your knowledge.

Feeding

Has your child ever had a feeding swallowing evaluation? Yes ◯ No ◯

Has your child ever had a video swallow study? Yes ◯ No ◯

If yes:

- Where was the evaluation/study done: _____
- When was the last evaluation/study completed: _____
- Is your child on modified diet as a result of video swallowing? Yes ◯ No ◯

Does your child show signs of reflux (heartburn)? Current: Yes ◯ No ◯ Past: Yes ◯ No ◯

If yes, how was your child's reflux managed? _____

Does your child see a dietitian or gastroenterologist (GI) doctor for feeding: Yes ◯ No ◯

If yes, please list their names and clinic names.

_____

_____

Has your child ever had a tracheostomy and/or used a ventilator? Yes ◯ No ◯

Home Feeding Environment

Please describe the location where meals typically occur and the type of chair/seating your child uses, and who is eating with your child. For example: Meals at the kitchen table my child in a high chair. Parents and brother also sit at the table.

_____

_____

Home Feeding Equipment

Check all the utensils/cups used by your child.

☐ Straws ☐ Spoon ☐ Fork ☐ Knife ☐ Sipper cup with valve ☐ Tube fed (g tube, j tube)

☐ Sipper without valve ☐ Double Handled Cup ☐ Open Rim Cup

Please list any adaptive cups, utensils, or alternative feeding methods that are used:

_____

_____

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Self-feeding Skills

Does your child use utensils to feed him or herself? Yes ◯ No ◯

Does your child have any of the following during or after meals?

- ☐ trouble going to sleep
- ☐ waking up often in the middle of the night
- ☐ is a restless sleeper
- ☐ arches back during feeding
- ☐ arches back after feeding
- ☐ turns head to the left during feeding
- ☐ frequent irritability
- ☐ frequent spitting up or vomiting (throwing up)
- ☐ frequent re-swallowing behavior noted after feeding
- ☐ frequent respiratory illness
- ☐ unexplained low grade fevers
- ☐ frequent upper respiratory infections
- ☐ Constipation: If managed, how: _____
- ☐ only eats small amounts at a time
- ☐ wants to eat often
- ☐ only prefers one or two food textures (for example: only smooth purees)
- ☐ has foul or sour breath
- ☐ doesn't want to be held after eating
- ☐ has had oral thrush (How often? _____)
- ☐ is upset by distractions such as music, or movement (car rides/swinging)
- ☐ has shallow breathing
- ☐ has rapid breathing, particular after eating
- ☐ doesn't want to move after eating

Bottle Feeding / Breastfeeding

☐ My child is not currently bottle or breastfed. At what age did your child stop bottle and/or breastfeeding? _____

Please skip the rest of this section and go to the next section.

My child is primarily ◯ breastfed ◯ bottle fed

About how long does each feeding take? _____ How many feedings per day? _____

At what age did your child start bottle feeding? _____ List type of bottle and nipple: _____

List formula type and amount used at each feeding: _____

Tube Feeding

☐ My child is not tube fed. *Please skip the rest of this section and go to the next section.*

Why was tube feeding started with your child? _____

Type of Tube: _____ Rate/Flow: _____

Formula (type) and ratio: _____ Receives all food through tube: Yes ◯ No ◯

What is your child's current recommended diet? (NPO, pleasure feedings, thickened liquids, etc.)

_____

Is there a plan in place for weaning your child off tube feeding? Yes ◯ No ◯

Liquids

☐ My child does not take liquids. *Please skip the rest of this section and go to the next section*

Does your child require liquids to be given in a thicker consistency? Yes ◯ No ◯

If yes, please mark consistency: ◯ honey thick ◯ nectar thick ◯ pudding thick

Describe the amount of liquids (ounces) your child drinks each feeding/meal and the number of bottles or glasses each day. If using glasses, please note the size (For example: three glasses, 8 ounces each.)

☐ Bottle: _____ ☐ Juice: _____

☐ Milk: _____ ☐ Other: _____

☐ Water: _____

Please mark the number of times that liquids are offered each day: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6

When your child drinks does he or she have any of the following concerns:

☐ wet vocal quality (congested, gurgly) ☐ throat clearing ☐ coughing ☐ drooling (leakage)

☐ signs of distress ☐ gagging ☐ nasal regurgitation (liquid out of nose) ☐ watery eyes

Other concerns you have regarding your child's ability to drink:

_____

_____

Does your child drink liquids at various temperatures? Check all that apply: ☐ room temperature ☐ cold ☐ warm

Purees

☐ My child does not eat purees. ***Please skip the rest of this section and go to the next section.***

In this section, please describe your child's ability to eat soft foods such as applesauce, puddings, ground foods (such as baby foods), or table foods (such as mashed potatoes).

At what age was your child introduced to pureed foods? _____

Was there an aversion to pureed foods when introduced? _____

Please mark the textures that your child will eat: ☐ smooth (pudding) ☐ slightly lumpy (cooked oatmeal)

☐ moderately lumpy (cooked oatmeal with small fruit chunks) ☐ lumpy texture (thick soup with cooked veggies)

Describe the typical pureed foods and amount your child eats at each meal.
For example: At breakfast: Oatmeal with fruit, 4oz.

☐ Breakfast: _____ ☐ Dinner: _____

☐ Lunch: _____ ☐ Snacks: _____

How long does it take your child to eat a meal of purees? Check the closest time range. If it varies due to the consistency of the puree, please comment as appropriate. _____

◯ 5-10 minutes ◯ 10-15 minutes ◯ 15-20 minutes ◯ 20-30 minutes ◯ Longer: _____

Please mark the number of times that purees are offered each day: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6

When eating purees, does your child ever have any of the following? If yes, please note how often this occurs.

☐ wet vocal quality (congested, gurgly) ☐ throat clearing ☐ coughing ☐ drooling (leakage)

☐ signs of distress ☐ gagging ☐ nasal regurgitation (liquid out of nose) ☐ watery eyes

Does your child eat foods at various temperatures? Check all that apply: ☐ room temperature ☐ cold ☐ warm

Solids

☐ My child does not eat solids. ***Please skip the rest of this section and go to the next section.***

In this section, please describe your child's ability to eat solid foods such as crackers, breads, fruits, vegetables, and meats.

Please mark the textures that your child will eat:

☐ chewy solids ☐ hard ☐ crunchy ☐ mixed texture ☐ dissolvable solids ☐ soft solids

Describe the typical solid foods and amount your child eats at each meal.
For example: At lunch: ½ peanut butter and jelly sandwich and apple wedges (4-6)

☐ Breakfast:_____ ☐ Dinner: _____

☐ Lunch: _____ ☐ Snacks: _____

About how long do mealtimes last when solid foods are offered?

◯ 5-10 minutes ◯ 10-15 minutes ◯ 15-20 minutes ◯ 20-30 minutes ◯ Longer: _____

Please mark the number of times that solid foods are offered each day: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6

Does your child eat foods at various temperatures? Check all that apply: ☐ room temperature ☐ cold ☐ warm

What type of preparation is required for your child to eat solid foods? Check all that apply.

☐ bite size ☐ whole ☐ shredded ☐ sliced ☐ no special preparation required

Please describe how safely you feel your child is with eating solid foods:

☐ safe with all

☐ safe with some _____

☐ throat clearing _____

☐ coughing _____

☐ signs of distress (describe)

_____

☐ risk of gagging

☐ risk of choking

☐ loss of food from mouth

☐ chews well _____

☐ chews soft foods well

_____

☐ only bites off foods, doesn't eat

_____

☐ foods is "pocketed" (left in the cheeks)

_____

Check or list any additional concerns that you as the parent(s) have relating to feeding.

☐ increase the amount of food my child eats

☐ increase the variety of foods my child eats

☐ increase the variety of textures of foods my child eats

☐ improve cup drinking

☐ improve chewing skills

☐ decrease tube feedings

☐ decrease gagging during eating

☐ increase weight gain

☐ decrease vomiting (throwing up) related to eating

☐ reduce or eliminate diarrhea

☐ reduce or eliminate constipation

☐ Other: Please list below.

Parent/Guardian Signature _____ Date/Time _____

Therapist Signature _____ Date/Time _____

Therapist Signature _____ Date/Time _____