

OUTPATIENT CLINIC: _____

Pediatric Feeding Evaluation History

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Child's Name: _____ **Date of Birth:** _____

Person Completing Form: _____ **Date Completed:** _____

Medical Diagnosis: _____

Height: _____ **percentile:** _____ % **Weight:** _____ **percentile:** _____ %

Feeding Difficulties Started When: _____

In relation to any precipitating event: _____

What are your Goals for Therapy: _____

Child's Current Means of Nutrition: Oral NG tube Gtube Other

LIST TYPE

Oral Liquids: _____

Oral Solids: _____

Oral Supplements (vitamins, calorie boosters etc): _____

Tube Feeding Formula: _____

Feeding Schedule (Begin with breakfast and include any Tube feedings during day and night):

Textures	NO Difficulty	Minimal Difficulty	Significant Difficulty	Refuses or Unable
Thin Liquids				
Thick Liquids				
Puree				
Lumpy				
Chopped				
Soft Chewy				
Complex/Hard Chewy				

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Gastrointestinal: No Problem or Describe: _____

Sleep: No Problem or Describe any sleep related concerns such as snoring, waking, crying beyond age expectation: _____

Elimination: No Problem or Describe any bowel or bladder problems: _____

Allergy or Sensitivity to any food: No Problem or Describe: _____

Skin: No Problem or Describe any rashes or skin problems: _____

Cardiac or Respiratory: No Problem or Describe: _____

Please indicate any problems during meals:

- | | | |
|--|--|---|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Overstuffing Mouth |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Difficulty Moving Food |
| <input type="checkbox"/> Choking | <input type="checkbox"/> Increased Congestion | <input type="checkbox"/> Difficulty Biting |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Drooling | <input type="checkbox"/> Difficulty Chewing |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Spillage From Mouth | <input type="checkbox"/> Other: |
| <input type="checkbox"/> GE reflux | <input type="checkbox"/> Holding Food In Mouth | |

Comments:

Indicate your child's temperature and taste preferences:

ITEM	Likes	Dislikes	No Preference
Hot Food			
Cold Food			
Room Temperature			
Salty Food			
Spicy Food			
Sour Food			
Sweet Food			

Describe your child's feeding equipment and utensils or self feeding difficulty:

Bottle: _____ Spoon: _____
 Nipple: _____ Fork: _____
 Cup(s): _____ Knife: _____
 Straw: _____ Finger Foods: _____

Indicate your child's position for feedings:

- Lap
- Infant Seat
- High Chair
- Regular Chair
- Booster Seat
- Other:

Describe any avoidance or aversive behaviors with respect to eating: _____

