SPEECH, LANGUAGE AND FEEDING DEPARTMENT
Feeding History

Patient Name: _____________________________ Person Completing Form: ______________________ Date: ____________

Your concerns about your child’s feeding:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

CHECK ANY FACTORS LISTED BELOW THAT APPLY:

Methods/utensils currently used:

- Breast
- Bottle/type of nipple used? __________
- Cup/type(s) used? _________________
- Spoon/type(s) used? ________________
- Fork
- Straw
- Fingers
- Tube feedings/type? ________________
- % of intake by tube ________________
- Other: ____________________________

Textures currently accepted:

- Formula: ___________________________
- Other thin liquids: __________________
- Thick liquids
- Commercial baby food
  - Stage I
  - Stage II
  - Stage III
- Ground or commercial junior food
- Food prepared in the blender
- Mashed soft table food
- Regular table foods (includes chewable)
- Only accepts certain types of foods (list)
__________________________________________________________________________________________
- Other: ____________________________

Feeding and sensory behaviors:

- Does not eat anything by mouth
- Problems gaining weight
- Takes insufficient amount
- Falls asleep while feeding
- Refuses (turns away, cries, wants down)
- Forgets to breathe while feeding
- Arches/draws legs up to stomach
- Changes color around face/mouth with feeding
- Snacks throughout the day
- Plays during mealtime
- Easily distractable
- Will not stay seated while eating
- Gags/vomits with new textures/tastes
- Throws food/utensils
- Does not like to be messy

Mealtime:

Duration (in minutes): __________

- 15
- 30
- 45
- 60
- >1 hour

Where is your child fed?

- On your lap
- In chair/type? ____________________
- In bed
- Other position(s):_________________

Person(s) who typically feed child:__________________________________________

Schedule: (For infant)

Intake amount: __________ Approximately every ____ hrs.

Estimated total per 24 hours:

How do you know your baby is ready to eat? _____________________________

Sleep/wake pattern: ______________________________________________________

Schedule: (For toddler and older)

Time: Meal/snack Typical foods: Amount:

__________________________________________________________________________

What would you like to find out from today’s evaluation?

__________________________________________________________________________

Other professionals with whom you have discussed your child’s feeding:

__________________________________________________________________________

Scan to: Multidisciplinary Notes >> Rehab Reports >> History Forms >> Rehab Patient History Form DOCIMG

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