Fundamental Therapies

Additional Information Sheet: Feeding Therapy

Please fill this out if you are interested in your child receiving speech/language therapy at Fundamental Therapies and if you have concerns with any of the following areas, please explain.

Has your child been tested for allergies? ☐ Yes ☐ No Notes: _____
Has your child been tested for reflux? ☐ Yes ☐ No Notes: _____
Has your child had a swallow study? ☐ Yes ☐ No Notes: _____
Does your pediatrician or specialist have any concerns with weight or growth of your child? ☐ Yes ☐ No Notes: _____
What is the current method of feeding? ☐ NPO ☐ PO ☐ NG Tube ☐ G Tube ☐ GJ Tube
Was your child successful with a bottle? ☐ Yes ☐ No Notes: _____ Problems observed: _____
When did your child begin solids (cereal, baby food)?
Did your child progress through solids? ☐ Yes ☐ No Check all that apply: ☐ Baby Cereal ☐ Stage 1 ☐ Stage 2 ☐ Stage 3 ☐ Purees ☐ Soft chewables ☐ Hard chewables
Does your child drink a variety of liquids? ☐ Yes ☐ No Which ones: _____ When? ☐ Before meals ☐ During meals ☐ After meals Via: ☐ Bottle ☐ Sippy cup ☐ Drink box ☐ Open cup ☐ Straw
Is your child able to self-feed? ☐ Yes ☐ No With: ☐ fork ☐ spoon ☐ finger feed Is there any spillage when using utensils? ☐ Yes ☐ No
What is your child's arousal level during feeding? ☐ Deep sleep ☐ Light sleep ☐ Drowsy ☐ Quiet/alert ☐ Active/alert ☐ Crying ☐ Other Describe: _____
What behaviors does your child exhibit during feeding?
Does your child receive supplemental feedings? ☐ Yes ☐ No If yes, describe:
Describe the environment where your child usually eats (such as room, type of chair, music/tv on):
Does your child eat ☐ more ☐ less (choose one) in different environments (in school, outside events, etc)? **Does your child eat ☐ same ☐ different (choose one) in different environments?**
Please list your child's favorite foods to eat:
Please list any foods your child refuses:
If different from your child's refused foods, please list foods that are difficult for your child to eat:
Is there a texture/consistency that your child prefers? ☐ Puree ☐ Lumpy ☐ Crunchy ☐ Liquids ☐ Chewy ☐ Other

Fundamental Therapies

Feeding Schedule:

Breakfast

Time: _____

Foods (please list): _____

_____

Lunch

Time: _____

Foods (please list): _____

_____

Dinner

Time: _____

Foods (please list): _____

_____

Snacks

Time: _____

Foods (please list): _____

_____

Please list any evaluations and/or treatments if you have previously tried to help your child with their feeding difficulties:

Please describe any other comments about your child's feeding:

What are your goals for your child in regards to their feeding?:

We appreciate your time and participation in helping us provide a thorough feeding evaluation for your child. Please bring the following items to the evaluation:

- Previous feeding evaluation reports (i.e. swallow studies), GI evaluations
- Any special seating equipment that you are currently using for feeding time
- Typical utensils used for feeding (bottle, cup, fork, plate, etc)
- Unsuccessful or refused food items
- Preferred food items
- Variety of textured foods:
    - Purees- baby foods, applesauce, pudding
    - Soft chewables- cooked vegetables, banana
    - Hard/crunchy chewables- cereal, crackers, chips