Central Delaware Speech Language Pathology, Inc.

Specializing in the Diagnosis and Treatment of Speech-Language Disorders
ASHA Certified, Licensed in Delaware

Feeding Program

Today's Date:_____ Date of Birth:_____

Child's Name:_____

Parent/Guardian's Name(s):_____

Address:_____

City, State, Zip:_____ Telephone:_____

_____

Most recent height:_____ weight:_____ When were they taken?_____

Educational Service Provider:_____

(school or early intervention agency)

Teacher or Therapist:_____

Primary Physician:_____

Address:_____

City, State, Zip:_____

Telephone:_____

Other Specialists (Name and Phone):

Gastroenterologist:_____

Allergist:_____

Metabolic Specialist:_____

Developmental Pediatrician:_____

Dietician:_____

Other:_____

541 S. Red Haven Lane, Dover, DE 19901 (Phone) 302-674-3350 (Fax) 928-752-335

Does the child have medical insurance?___Yes___No (***please include a photocopy of the cards, front and back)***

If yes, what type?_____

Policy # and holder:_____

Group #:_____Type:_____

Prenatal and Birth History:

Describe mother's general health during pregnancy (illnesses, accidents, medication requirements, etc.):

Length of pregnancy: _____ Child's Birth Weight: _____

Describe delivery (any complications):

Describe child's general health at birth:

Child's length of stay in hospital:

Medical History:

Child's general health is: Good Fair Poor

Please provide approximate ages at which your child has experienced any of the following illnesses/conditions:

Adenoidectomy_____Headaches_____ Pneumonia_____

Asthma_____Head Injury_____ Seizures_____

Allergies_____Hearing Loss_____ Sinusitis_____

Chicken pox_____Heart Problems_____Sleeping Difficulty_____

(Frequent) colds_____High Fevers_____Thumb/Finger Sucking_____

Croup_____Influenza_____Tonsillectomy_____

Constipation _____ Diarrhea _____

Ear Infections_____Measles_____Vision Problems_____
How often? _____Ear Tubes_____

Epilepsy_____Mumps_____

Meningitis_____ Other_____
When? _____ _____

Describe any major accidents, surgeries, illnesses, or hospitalizations your child has had:

Is your child currently under a physician's care? If yes, why?

Please list any medications your child is currently taking:

Has your child had any negative reactions to medication? Please describe:

Are your child's immunizations up to date?

Is your child sensitive to latex?

Does your child have any of the following problems? Please include when each problem started.

_____Food refusal (refusing all of most food) When did this start?:_____

_____Food Selectivity by texture (eating only textures that are not developmentally appropriate) When did this start?:_____

_____Food Selectivity by Type (eating a narrow variety of foods) When did this start?:_____

_____Oral Motor Delays (problems with chewing, lip closure, or tongue lateralization) When did this start?:_____

_____Dysphagia (problems with swallowing) When did this start:?
_____

_____Abnormal preferences (e.g. refuses food is not a certain temperature, eats only certain brands, must have a certain cup or special silverware to eat)
Describe:_____
When did this start?:_____

_____Food Allergies (Please List)_____

_____Reflux, Choking, Gagging Episodes
When did this start? _____ Is it documented by a GI or specialist? _____ Any medications?
_____

_____Other feeding problems?(describe)_____

What issues are you trying to resolve? (Check as many as apply)

	Increase the volume of food my child eats		Increase the texture of food my child eats
	Increase the variety of food my child eats		Improve drinking cup behaviors
	Improve oral motor skills		Improve mealtime behaviors
	Decrease gagging during eating		Decrease vomiting related to eating

	Reduce/eliminate diarrhea		Reduce/eliminate constipation
	Increase weight gain		Decrease tube feedings
	Resolve reflux or other GI issues		Other

Where does your child eat? (Check all that apply)

	Caregiver's lap		Booster seat		Infant seat
	High chair		Chair at the table		Other

Does your child have any of these issues at mealtimes? (Check all that apply)

	Throws food during meal		Messy eater
	Spits out food		Takes food from others
	Cries or screams at meal		Refuses to self-feed
	Leaves the table before finished		Over-eats

Food Consistency: Please check all that are applicable:

Food Consistency	Does eat	Can eat	Never Tried	Can't eat
Breast/Bottle				
Thin baby food cereals				
Stage 1 baby food				
Stage 2 baby food				
Soft mashed table food				
Hard munchables (licorice, carrot stick)				
Meltable Hard Solids (Gerber stars)				
Soft Cubes/Mechanical				
Mixed Texture (chunky soups)				

Describe any special diet. _____

Please list any other medical diagnosis, condition, surgeries, consults, and tests that have been administered that are related to feeding (eg. Endoscopy, Modified Barium Swallow Study etc) and the dates:

_____

_____

_____

***Please note that if a previous medical condition exists (such as delayed stomach emptying, NPO recommendation by a doctor etc.), a script from the recommending doctor will be mandatory to provide clearance for this type of evaluation.**

Current medications and dosages:_____

List all known allergies/sensitivities:_____

Current Oral - Motor Status

Do you have any problems or concerns with? (check all that apply)

	Drooling		Poor Sucking
	Poor tongue control		Problems with biting
	Poor lip control		Lack of chewing
	Swallowing problems		Hypersensitive to temperature, texture, etc.
	Teeth grinding		Sweating while eating
	Coughing/gagging		Ruminating/Vomiting

Were any of the following ever used? (Please circle)

Tracheotomy tube NG tube nasal cannula gastrostomy tube

Current Tube Feeding Information

Type of feeding tube (please circle): G-tube J-tube NG-tube NJ-tube

Type of formula used:_____

What does your child receive from the tube feeding in 24 hours (please specify formula, water, etc)?

Continuous feeding:
How much per hour_____Time feeding run (start time/stop time)_____

Circle the appropriate answer:

How many times per week does your child vomit during or within one hour of tube feeding?
0 times 1-3 times 4-6 times 7-9 times 10 or more times

How much does your child typically vomit?
Less than one tablespoon About one tablespoon
More than one ounce

How many times per week does your child gag or retch during or within one hour of tube feeding?

0 times 1-3 times 4-6 times 7-9 times 10 or more times

How many times per week does your child cry during or within one hours of tube feeding?

0 times 1-3 times 4-6 times 7-9 times 10 or more times

How many times per week does your child **sleep through the night** without awakening?

0 days 1-2 days 4-5 days 6-7 days

How often does your child experience problems with constipation?

Daily Weekly Monthly

How often does your child experience problems with diarrhea?

Daily Weekly Monthly

Have you had difficulty increasing the rate or volume of your child's tube feeding?

Y N

Has your child had difficulty gaining weight on the current tube feeding schedule? Y N

Current Feeding Skills (check all the apply)

_____drinks from the bottle _____held by caregiver _____child hold bottle

_____feeds self with fingers

_____feeds self with spoon _____with help _____without help

____feeds self with fork _____with help _____without help

____drinks from open cup/glass _____with help _____without help

____drinks from sippy/tippy cup _____with help _____without help

Meal Time Routines:

List any/all primary feeders (eg. Mother, grandmother, Nanny etc)

_____

List any/all locations for 3 major meals (eg. Parent's house, Daycare etc)

_____

List any/all people present during the meals (eg. Siblings, friends etc.)

_____

List any/all reinforcers needed during meals (eg. Praise, TV, toys etc.)

_____

Please briefly describe a typical dinner meal and the child's participation during the meal.

_____
_____
_____
_____

Please List:

a. Favorite foods:_____
b. Favorite recreational materials: _____
c. Favorite activities:_____

Please feel free to write any other information that you feel is important for the feeding team to know about your child and his/her eating habits:

_____
_____
_____
_____
_____
_____
_____
_____

***Please note again that if a previous medical condition exists (such as delayed stomach emptying, NPO recommendation by a doctor etc.), a script from the recommending doctor will be mandatory to provide clearance for this type of evaluation.**

____ I understand and agree to the statement above. I am attesting that the information I provided regarding my child's medical status is accurate and current.

Parent Signature: _____
Date: _____

Thank you! Please mail or drop off the necessary information to our facility. We look forward to working with you!