We assess and provide individualized treatment for children experiencing developmental feeding delays, oral-motor deficits, and sensory-based feeding challenges. Our services are directed towards developing the skills necessary, and providing the social-emotional support, to promote a positive mealtime experience. We integrate neurodevelopmental, oral-motor, sensory and relationship-based approaches into our treatment.

Treatment of feeding disorders often requires coordination of services from a multidisciplinary team. If during the initial patient intake or assessment process, additional needs or support are identified, appropriate recommendations for services will be made.

In order to provide you with the best possible Evaluation, we need additional information regarding your child's current feeding skills, your primary concerns and any other medical information or history that will be helpful in the assessment process. The forms below are needed prior to scheduling your child's Evaluation:

- ❒ Feeding History and Mealtime Routines
- ❒ Food Intake Form
- ❒ 3-Day Food Log
- ❒ Any other medical information or reports that may assist us in understanding your child's medical or feeding history (i.e. Speech Therapy, hospital reports, swallow studies etc…)

On the Day of your Childs Evaluation

- ❒ Please bring food and drink items that your child likes as well as food that they have difficulty with. It is helpful to bring a variety of textures, if applicable.
- ❒ Please bring utensils that your child uses regularly at home, such as bottle, nipple, spoon and/or fork.
- ❒ Bring your child hungry, but not uncomfortable.

When you come for your evaluation, please arrive 15 minutes early so we are able to complete any paperwork with you and obtain financial information.

Bring your insurance card (please bring all cards, if you have more than one plan). If you have any questions, please feel free to call our office at 503-657-8903.

~Thank you from all of us at Neurotherapeutic Pediatric Therapies! We look forward to serving you and your child!

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Feeding History and Mealtime Routines

Child's Name:	Date of Birth:
Diagnosis:	Age:
Physician:	Today's Date:

Please describe your primary concerns regarding your child's eating:

_____

_____

_____

_____

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

- ❒ Increase the volume of food my child eats
- ❒ Increase the variety of foods my child eats
- ❒ Improve oral motor skills
- ❒ Decrease gagging during eating
- ❒ Reduce/eliminate diarrhea
- ❒ Increase weight gain
- ❒ Resolve reflux or other GI issues
- ❒ Increase the texture of food my child eats
- ❒ Improve cup drinking
- ❒ Improve mealtime behaviors
- ❒ Decrease vomiting related to eating
- ❒ Reduce/eliminate constipation
- ❒ Decrease tube feedings
- ❒ Other:

Medical and Developmental Feeding History

1. Please describe all that apply:

- ❒ History of Oxygen and Ventilation Support Following Birth:

  _____
- ❒ History of NG tube feeding: _____
- ❒ History of Tracheotomy: _____
- ❒ History of G-tube feeding: _____
- ❒ Surgical History: _____
- ❒ History of Poor Weight Gain: _____
- ❒ History of Failure to Thrive: _____

❒ History of Feeding Difficulties as an Infant (colic, reflux, difficulty nippling, etc.):

_____

_____

2. **Is your child currently being treated for reflux?** ❒No ❒Yes
3. **Current Percentiles for: Height: _____ Weight: _____ Head Circumference: _____**
4. **Current Medications:**

Medication:	Purpose:	Dose/day:
Medication:	Purpose:	Dose/day:
Medication:	Purpose:	Dose/day:

5. **Please note indicate whether your child regularly experiences the following symptoms/behaviors:**

❒ Spits Up: _____
❒ Spits Up/Re-swallows:_____
❒ Wet Burps: _____
❒ Wet Pillow After Sleeping: _____
❒ Frequent Sore Throat: _____
❒ Hoarse Voice or Cry: _____
❒ Arching: _____
❒ Colicky/Fussy Behavior: _____
❒ Painful Swallow: _____
❒ Abdominal Pain/Cramping: _____
❒ Gagging: _____
❒ Choking: _____
❒ Nasal Regurgitation:_____
❒ Stops Eating after Small Amts. of food/drink _____
❒ Persistent, Non-seasonal cough: _____
❒ Noisy Breathing:_____
❒ Wet, "gurgly" voice sounds: _____
❒ Wheezing: _____
❒ Frequent Chest Colds: _____
❒ Frequent Ear Infections: _____
❒ Hives: _____
❒ Rash:_____
❒ Eczema:_____
❒ Itching: _____
❒ Sneezing, Runny Nose: _____
❒ Vomiting: _____

Has your child ever had a problem with: ❒vomiting ❒gagging ❒choking

If yes, when did the problem start? _____

How and when was the problem resolved? _____

When does vomiting occur?

❒ During feeding?
❒ After feeding?
❒ Unrelated to feeding?
❒ When upset

How often does vomiting occur?

____ times per day
____ times per week
____ times per month
____ occasionally

Are stools usually: ❒watery ❒formed ❒runny ❒pasty ❒constipated ❒foul smelling

Has your child ever had a problem with ongoing constipation? ❒No ❒Yes

Does your child have any food allergies? ❒No ❒Yes, *please list:*

_____

6. Has your child ever had any of the following studies? Please attach copies of studies if you have them and/or include the physician or hospital involved on you release of information:

❒ **Chest X-Ray**	Date:
❒ **Videofluroscopy** (*an X-ray procedure done to evaluate the safety of swallowing)*	Date:
❒ **Upper GI series** (*a barium swallow in order to take specialized X-rays of the esophagus and stomach)*	Date:
❒ **Endoscopy** (*a small tube with a light and camera lens is used to examine the inside of the digestive tract.)*	Date:
❒ **Gastric Emptying Scan** (s*pecial X-ray exam to identify abnormalities related to emptying of the stomach.)*	Date:
❒ **PH study** (*a small probe is inserted via the nose to measure stomach acid.)*	Date:
❒ **Allergy Studies**	Date:

Please comment on results of testing noted above:

_____

_____

_____

_____

Mealtime Routines and Behaviors

1. Describe your child's daily schedule for mealtimes and snacks:

_____

_____

2. How long do mealtimes usually take? _____

3. Please list all the locations where your child regularly eats and note who is present. (*For example; in kitchen with grandma, at the snack table in preschool with ten kids, etc…)*

_____

_____

_____

4. Does your child eat better in some locations than in others?

_____

_____

5. Does your child feed himself? *Check all that apply:*

❒ holds bottle ❒ uses cup ❒ eats finger foods ❒ uses spoon ❒ uses fork

Comments: _____

_____

6. If your child needs help eating, who feeds him/her? _____

7. Does your child eat differently for some family members or caretakers than others? _____

8. Seating and Positioning at Mealtimes:

❒ Parent's Arms: _____ ❒ Child Table & Chair: _____

❒ High Chair: _____ ❒ Adult Table & Chair: _____

❒ Booster Seat: _____ ❒ Does not sit for meals/snacks: _____

❒ Adapted Seating: _____

9. Please describe the utensils your child uses at meals and snacks:

❒ Bottle/Nipple: _____ ❒ Cup: _____

❒ Spoon: _____ ❒ Fork: _____

❒ Plates: _____ ❒ Straw: _____

❒ Adapted Equipment: _____

10. Does your child have any of the following problems? *Please include estimated date of onset:*

❒ Food refusal *(refusing all or most foods)*	Onset:
❒ Food Selectivity by Texture *(eating only textures that are not developmentally appropriate)*	Onset:
❒ Food Selectivity by Type *(eating only a narrow variety of foods)*	Onset:
❒ Food Selectivity by Type *(eating only a narrow*	Onset:
❒ Dysphagia *(problems with swallowing, painful swallow, aspiration)*	Onset:
Describe:	
❒ Abnormal *preferences (refuses food if not a certain temperature, eats only certain brands, must have a certain cup or special silverware to eat)*	Onset:
Describe:	

11. Does your child show any of the following behaviors during meal or snack time?

- ❒ Reluctant to touch certain textures of food: _____
- ❒ Spitting out certain textures _____
- ❒ Cough or gag with foods in mouth: _____
- ❒ Pockets food in mouth: _____
- ❒ Can't locate or loses food in mouth: _____
- ❒ Swallow food whole or barely chewed: _____
- ❒ Overstuff mouth: _____
- ❒ Grinds teeth: _____
- ❒ Turn head away: _____
- ❒ Looking away from foods: _____
- ❒ Distress with sight of foods on table: _____
- ❒ Distress with sight of foods on plate: _____
- ❒ Cough or gag with sight of food: _____
- ❒ Covers ears during meal: _____
- ❒ Distracted and Inattentive during meals: _____
- ❒ Eye blinking or watering: _____
- ❒ Covering nose: _____
- ❒ Cough or gag to smells: _____

Do you have any concerns about your child's behavior during meals and snacks? *Please describe:*

_____

_____

_____

_____

What do you do when your child is demonstrating his/her behaviors during meal time?

_____

_____

12. What feeding techniques do you use with your child to get him/her to eat?

❒ Coax	❒ Distract w/toys	❒ Limit food	❒ Threaten	❒ Change schedule
❒ Spank	❒ Offer reward	❒ Mini-meals	❒ Force feed	❒ Ignore
❒ Praise	❒ Time out	❒ Use television	❒ Change foods offered	

Other: _____

13. Please describe your child's communication about feeding:

How does your child communicate he/she is hungry?

_____

_____

How does your child indicate what he/she wants?

_____

_____

How does your child indicate that he/she wants more?

_____

_____

How does your child indicate what he/she doesn't want?

_____

_____

How does your child indicate when he/she is done?

_____

_____

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Food Intake Form

Child's Name:	Age:
Date of Birth:	Date:

Overall description of Appetite

❒ Good ❒ Fair ❒ Poor ❒ Varies Meal to Meal ❒ Varies Day to Day

Best Time of Day to eat: _____

List your child's favorite foods (include brand name if this makes a difference to them)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

List your child's beverages (include brand name if this makes a difference to them)

1. _____

2. _____

3. _____

List any food you would like to see your child eat

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Food Texture - Please check the textures of food that your child can/will eat. *Examples are provided*

- ❒ Puree *(smooth, not too thick with no lumps; i.e. pudding, applesauce, baby foods)*
- ❒ Soft Mashed *(soft foods with uniform texture; i.e. mashed potato, mashed squash)*
- ❒ Dissolvable Solids *(dry solids with uniform texture that melt in mouth; i.e. cheese puffs)*
- ❒ Soft Cubes *(soft, bite-sized food that holds shape; i.e. banana cube, avocado cube)*
- ❒ Soft Mechanical *(soft foods that don't require extensive chewing; i.e. scrambled eggs, thin sliced deli meats)*
- ❒ Mixed Textures *(soft foods with more than one texture; i.e. mac & cheese, soft grilled cheese)*
- ❒ Hard Mechanical/Crunchy *(hard exterior that require some grinding/chewing; i.e. nuts, Fritos corn chips)*
- ❒ Chewy Solids *(i.e. dried fruit, meat strips)*
- ❒ Hard chewy solids *(i.e. raw vegetables such as carrots, jerky, streak)*

Taste Preferences:

❒ Salty ❒ Sweet ❒ Spicy ❒ Bland ❒ Other: _____

Temperature Preferences:

❒ Hot ❒ Warm ❒ Cool ❒ Cold ❒ Other: _____

Is your child on a special diet?

_____

_____

Does your child have any food allergies?

_____

_____

Are there foods that your child used to eat that she/he now rejects? *Please list:*

_____

_____

Does your child appear to crave certain foods?

_____

_____

_____

Food Checklist

Please check the boxes for food that your child will currently eat. **Please note if your child will only eat a certain type or brand, or only if prepared in a certain way**.

Chips/Snacks:

❒ Crackers: _____ ❒ Potato Chips:_____ ❒ Pretzels:_____ ❒ Popcorn:_____

❒ Granola Bars:_____ ❒ Snack Mix: _____ ❒ Cheese Puffs:_____ ❒ Goldfish:_____

❒ Taco Chips:_____ ❒ Hiker's Mix:_____

❒ Other: _____

Breads/Cereals/Grains:

❒ Hot Cereal: _____ ❒ Dry Cereal: _____ ❒ Breakfast Bar:_____ ❒ Pop Tart: _____

❒ Pancakes: _____ ❒ Waffles: _____ ❒ French Toast: _____ ❒ Bread, Untoasted: ___

❒ Toast: _____ ❒ Rolls/Buns: _____ ❒ Muffins: _____ ❒ Doughnuts:_____

❒ Cake: _____ ❒ Pita: _____ ❒ Tortilla(soft): _____ ❒ Taco Shells: _____

❒ Pizza Crust: _____ ❒ Rice: _____ ❒ Other Grains: _____ ❒ Bread Sticks: _____

❒ Garlic Bread: _____ ❒ Biscuit:_____ ❒ Cookies: _____

❒ Other: _____

❒ Types of Breads: _____

❒ Types of Pastas: _____

❒ Toppings if any on toast, pancakes, etc.:_____

❒ Sauces if any on pastas (spaghetti sauce, cheese, etc.): _____

❒ Milk on cereal? _____

Potato Products:

❒ French Fries: _____ ❒ Tator Tots: _____ ❒ Hash Browns:_____ ❒ Fried Potatoes: _____

❒ Baked Potatoes: _____ ❒ Potato Wedges:_____ ❒ Shoestring Fries:_____ ❒ Mashed Potatoes:_____

❒ Scalloped Potatoes: _____ ❒ Sweet Potato Fries: _____

❒ Baked Sweet Potatoes: _____ ❒ Other**:** _____

Cheese/Dairy:

❒ Milk: _____ ❒ Cheddar: _____ ❒ American:_____ ❒ Parmesan:_____

❒ Swiss:_____ ❒ Monterey Jack: _____ ❒ Mozzarella: _____ ❒ Colby:_____

❒ Cottage Cheese:_____ ❒ Sour Cream: _____ ❒ Whipped Cream: _____ ❒ Cream Cheese: _____

❒ Breakfast Drinks (Flavors/Types): _____

❒ Ice Cream (Flavors/Types): _____

❒ Yogurt (Flavors/Types): _____

❒ Other: _____

Fruit: (*Please indicate if raw, dried, and/or canned)*

❒ Apple: _____ ❒ Banana:_____ ❒ Blueberries: _____ ❒ Cantaloupe:_____

❒ Cherries:_____ ❒ Grapes:_____ ❒ Raisins:_____ ❒ Kiwi:_____

❒ Pear:_____ ❒ Watermelon: _____ ❒ Raspberries: _____ ❒ Strawberry: _____

❒ Pineapple: _____ ❒ Papaya: _____ ❒ Tangerine: _____ ❒ Peach:_____

❒ Lemon: _____ ❒ Lime:_____ ❒ Orange:_____ ❒ Grapefruit: _____

❒ Watermelon _____ ❒ Melons: _____ ❒ Cranberry _____ ❒ Fruit Cocktail: _____

❒ Fruit juices of any kind? _____

❒ Fruit inside breakfast bars/pop tarts: _____

❒ Fruit mixed with yogurt: _____

❒ Fruit toppings or jams: _____

❒ Fruit fillings in pies: _____

Vegetables: *(Please note if raw, canned, cooked, or baby food)*

❒ Green Beans: _____ ❒ Broccoli:_____ ❒ Cauliflower: _____ ❒ Corn:_____

❒ Squash:_____ ❒ Cucumber: _____ ❒ Zucchini:_____ ❒ Spinach: _____

❒ Carrots:_____ ❒ Lettuce:_____ ❒ Cabbage:_____ ❒ Coleslaw: _____

❒ Sweet Potatoes: _____ ❒ Tomatoes:_____ ❒ Asparagus: _____ ❒ Brussel Sprouts:_____

❒ Green Pepper:_____ ❒ Red Pepper: _____ ❒ Onion: _____ ❒ Mushroom:_____

❒ Peas:_____ ❒ Salsa: _____ ❒ Lettuce: _____

❒ Other: _____

Meats/Poultry/Fish/Eggs:

❒ Baked Chicken: _____ ❒ Chicken Nuggets:_____ ❒ Fried Chicken: _____ ❒ Turkey:_____

❒ Baked Fish: _____ ❒ Fried Fish: _____ ❒ Fish Sticks: _____ ❒ Tuna: _____

❒ Shellfish:_____ ❒ Hamburger:_____ ❒ Meatballs: _____ ❒ Ribs: _____

❒ Steak: _____ ❒ Roast Beef: _____ ❒ Pork Roast:_____ ❒ Pork Chops: _____

❒ Deli Meat: _____ ❒ Bologna: _____ ❒ Salami: _____ ❒ Hot Dogs: _____

❒ Sausage: _____ ❒ Bacon: _____ ❒ Ham: _____ ❒ Scrambled Egg: _____

❒ Fried Egg:_____ ❒ Boiled Egg:_____ ❒ Omelet:_____ ❒ Tofu:_____

❒ Nuts or Nut Butters: _____

❒ Soy Products: _____

❒ Meat Substitutes: _____

❒ Other: _____

Condiments:

❒ Ketchup: _____ ❒ Mayonnaise: _____ ❒ Miracle Whip: _____ ❒ Spicy Mustard:_____

❒ Honey Mustard:_____ ❒ BBQ Sauce:_____ ❒ Steak Sauce: _____ ❒ Salad Dressing:_____

❒ Butter/Margarine: _____ ❒ Gravy:_____ ❒ Honey:_____ ❒ Maple Syrup: _____

❒ Jelly: _____ ❒ Jam: _____ ❒ Chocolate Sauce: _____ ❒ Fruit Toppings: _____

❒ Caramel Sauce: _____ ❒ Chip Dip: _____

❒ Sauces, Dips & Toppings:

_____

_____

❒ Other: _____

Liquids:

❒ Milk:_____ ❒ Soy Milk:_____ ❒ Rice Milk: _____ ❒ Flavored Milk:_____

❒ Milk Shakes: _____ ❒ Lemonade: _____ ❒ Breakfast Drinks: _____ ❒ Water: _____

❒ Tea: _____ ❒ Smoothies:_____ ❒ Soda:_____

❒ Juice (List types): _____

❒ Caloric Supplements (List types & flavors): _____

❒ Other: _____

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3-Day Feeding Record

We would like to get a thorough understanding of the foods eaten in a period of time by your child. It is important to include details in the feeding record. Please help us by following the directions below:

1. List everything your child eats or drinks for three days.
2. Please indicate serving size of each item. For example, a 1-cup bowl of cornflakes, a 6-ounce glass of orange juice, or 1-teaspoon of butter.
3. Indicate type of milk or formula used and main ingredients of casseroles or salads. Remember to include details such as butter and jelly on toast, milk and sugar on cereal, and butter and/or gravy on potatoes.

Examples of good information:

Breakfast
1 cup cornflakes
4 ounces whole milk
2 teaspoons sugar
6 ounces orange juice
½ piece of toast with butter & jelly

Lunch
1 cup chicken noodle soup
4 Ritz crackers
6 ounces whole milk

Dinner
1 chicken leg, fried
6 ounces whole milk
½ small baked potato
1 teaspoon butter
1 Tablespoon peas
6 Ounces whole milk

Examples of not enough information:

Breakfast
1 spoonful of cereal
Juice
Toast

Lunch
2 sips soup
Crackers
Milk

Dinner
Meat
2 bites of potatoes
Vegetables
Milk

Thank you for taking the time to complete this 3 day food record!

Feeding Record

Day 1 Date	Child's Name	Present Height
	Date of Birth	Present Weight

Please fill out for three days. Include all foods and liquids taken orally and, if applicable, also include gastrostomy (GT) feedings. Be sure to **list ALL parts of each meal** as described in directions. Indicate if **fed by self, or caregiver**, and **any adaptations**.

TIME OF DAY OFFERED *How Long did it take to eat?*	FOOD OFFERED	AMOUNT OF FOOD EATEN	OFFERED BY

Feeding Record

Day 2 Date	Child's Name	Present Height
	Date of Birth	Present Weight

Please fill out for three days. Include all foods and liquids taken orally and, if applicable, also include gastrostomy (GT) feedings. Be sure to **list ALL parts of each meal** as described in directions. Indicate if **fed by self, or caregiver**, and **any adaptations**.

TIME OF DAY OFFERED *How Long did it take to eat?*	FOOD OFFERED	AMOUNT OF FOOD EATEN	OFFERED BY

Feeding Record

Day 3 Date	Child's Name	Present Height
	Date of Birth	Present Weight

Please fill out for three days. Include all foods and liquids taken orally and, if applicable, also include gastrostomy (GT) feedings. Be sure to **list ALL parts of each meal** as described in directions. Indicate if **fed by self, or caregiver**, and **any adaptations**.

TIME OF DAY OFFERED *How Long did it take to eat?*	FOOD OFFERED	AMOUNT OF FOOD EATEN	OFFERED BY