Mass General Brigham
Spaulding Rehabilitation

Date Completed:_____

# Feeding and Swallowing Intake

## Patient Information

Patient Name: _____ Date of Birth:_____

## Background/Medical Information

Growth: Birth Weight_____lbs. _____oz. Current or last weight: _____ lbs. _____ oz. (date): _____
Birth Length: _____in. Current or last height: _____ ft. _____ in. (date): _____

Placement on growth curve: ◯Remaining steady ◯Lower/falling ◯Increasing

Do you have concerns with your child's growth? ◯Yes ◯No

Has your child been treated for growth problems? ◯Yes ◯No

If yes, please explain:_____

_____

Has your child had any procedures or medical studies related to swallowing? ◯Yes ◯No

If yes, provide study and date:_____

Has your child experienced difficulty with any of the following? (Check all that apply.)

☐ Prolonged high fevers ☐ Ear infections ☐ Cardiac issues ☐ Tongue tie
☐ Elevated lead levels ☐ Tonsils/adenoids ☐ Respiratory issues ☐ Lip tie
☐ Skin rashes/eczema ☐ Hearing ☐ Vision ☐ Dental issues

Please explain: _____

_____

Gastrointestinal: Does your child have or has your child ever had reflux? ◯Yes ◯No

If yes, please explain (age of onset, symptoms, if resolved, medications taken, imaging studies):

_____

_____

Did your child have a Nissen Fundoplication? ◯Yes ◯No If yes, date: _____

How often does your child have a bowel movement?_____

Does your child experience constipation or diarrhea? ◯Yes ◯No

If yes, explain: _____

Sensory: Check below if your child does not tolerate the following:

☐ Being messy in play ☐ Having food on hands or face ☐ Loud noises ☐ Certain clothes/tags
☐ Bright lights ☐ Brushing teeth ☐ Baths/Showers ☐ Other:_____

Please describe: _____

Check below if any of the following apply to your child:

☐ Unaware when face is messy ☐ Mouth non-food items
☐ Seek movement ☐ Struggle to sit for meals

Please describe: _____

Does your child have difficulty falling asleep? ◯Yes ◯No Staying asleep? ◯Yes ◯No

If yes, please explain:_____

_____

## Feeding/Swallowing History

Was your child bottle or breastfed as a baby? ◯ Yes ◯ No If breastfed, at what age did you wean the baby? _____

Did your child have any challenges with early breast or bottle feeding? ◯ Yes ◯ No

If yes, please explain:_____

Did your child require formula changes? ◯ Yes ◯ No

At what age did you first introduce solid foods?_____

| Texture | Age Introduced | Type of Foods | Difficulties/Notes |
|---|---|---|---|
| Stage 1 baby food (purees)/infant cereals | | | |
| Stage 2 baby food (strained foods/thick purees such as oatmeal) | | | |
| Stage 3 baby foods (pureed with chunks) /mashed/chopped | | | |
| Table foods | | | |

How did your child tolerate the transitions to new foods?_____

_____

Has your child shown regression in their feeding? ◯ Yes ◯ No If yes, when: _____

Were there any contributing factors to the regression (e.g., illnesses, family changes or moves, accidents)? _____

_____

Has your child ever received supplemental or primary tube feeding? ◯ Yes ◯ No

Type: (NG, G, G-J, J, TPN): _____ When was tube placed?_____Reason: _____

Please describe current administration parameters (# feeds/day, frequency, length, Bolus/gravity, formula):

_____

_____

Does your child finger feed? ◯ Yes ◯ No

Does your child drink from the following? (Check all that apply.)

☐ Bottle ☐ Sippy cup ☐ 360 cup ☐ Open cup ☐ Straw

Is your child able to use the following utensils? (Check all that apply.) ☐ Spoon ☐ Fork ☐ Knife

Where does your child usually sit at mealtimes?

☐ Highchair ☐ Chair ☐ Standing at/near table ☐ In front of the TV

☐ Booster seat ☐ Eats on the move ☐ Caregiver's lap ☐ In the car

Who typically feeds your child?

☐ Self feeds ☐ Mother ☐ Father ☐ Sibling

☐ Grandparent ☐ Daycare provider ☐ Teacher ☐ Other:_____

How long does a meal take?_____ How many meals/snacks during the day? _____ Night?_____

Where and with whom does your child eat the best?_____

Are the people who commonly feed/eat with your child implementing everything the same way? ◯ Yes ◯ No

Does your child require distractions to eat? ◯ Yes ◯ No If yes, explain:_____

_____

How would you describe your child's interest in food/appetite? ☐ Good ☐ Fair ☐ Poor ☐ Varies

Please describe:_____

_____

Does your child eat a good volume of preferred foods? ◯ Yes ◯ No

How does your child communicate hunger or thirst? _____

When eating, does your child do any of the following? (Check all that apply.)

| | | | |
|---|---|---|---|
| ☐ Spit out food | ☐ Gag on food | ☐ Cough while eating | ☐ Cough after eating |
| ☐ Throw food/utensils | ☐ Stuff food in their mouth | ☐ Hold food in mouth/cheeks | ☐ Eat limited amount of food |
| ☐ Cry or scream | ☐ Refuse food | ☐ Vomit | ☐ Try to leave seat/table |

Is mealtime stressful? ☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

What do you do when your child does not eat appropriately?_____

What have you done to try to help your child with his/her feeding problem?_____

_____

_____

Does your family follow a special diet? (If so, please explain): _____

_____

Please list the foods/types of foods your child eats on a regular basis:

| Fruits | Vegetables | Dairy (milk, cheese, yogurt, ice cream) | Proteins (meats, poultry, fish, eggs, beans, nuts) | Carbohydrates (breads, grains, cereals, crackers, cookies, rice, pasta, snack foods) | Drinks, liquids, formula |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Are there specific textures, flavors or temperatures your child avoids? ◯ Yes ◯ No

Please list: _____

If applicable, please list any previously eaten foods that are no longer tolerated due to increasingly selective eating:

_____

Please share any additional information you would like us to know about your child: _____

_____

_____

What are your goals for therapy? _____

_____

**Parent/Guardian Signature:** _____ **Date:** _____

**Relationship to patient**: _____