Mass General Brigham
Spaulding Rehabilitation

Date Completed:_____

Infant 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

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

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 colic? ◯ Yes ◯ No

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

When did your child begin eating? _____

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

Did your child have any challenges with breastfeeding? (e.g. poor suck/poor latch/slow to feed) ◯ Yes ◯ No

If yes, please explain:_____

Has your child ever been bottle fed? ◯ Yes ◯ No

Were there any problems with bottle feeding? (e.g. poor suck/poor latch/slow to feed) ◯ Yes ◯ No

If yes, please explain: _____

What brand of bottle? _____ Type of nipple? _____

What kind of formula? _____ Did your child require formula changes? ◯ Yes ◯ No

If yes, please explain: _____

_____

Has your child experienced spoon feeding? ◯ Yes ◯ No If yes, when: _____

Describe foods presented: _____

How did your child tolerate transitions to new foods? _____

_____

How often is your child fed? _____

How is your child positioned for bottle feeding? (e.g. held by caregiver, swaddled in blanket, held facing away from or toward a caregiver, in a seating device or car seat) _____

How much liquid does your child consume at each feeding? _____

How long does each feeding take? _____

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

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

Has your child ever received supplemental or primary Tube feeding?

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

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

_____

_____

Who typically feeds your child?

◯ Mother ◯ Father ◯ Sibling ◯ Teacher ◯ Grandparent ◯ Daycare provide ◯ Other: _____

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

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

Does your child eat better in a sleepy state? ◯ Yes ◯ No

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

☐ Spit out food ☐ Gag on food ☐ Cough while eating ☐ Refuse bottle/food

☐ Cry or scream ☐ Vomit ☐ Hold food in their mouth/cheeks ☐ Eat a limited amount of food

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? _____

_____

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: _____