Speech & Voice Experience

Feeding Supplement – Pediatric

I. General Information

Child's Name:_____ DOB:_____

Parent/s:_____

Phone Number:_____ Email: _____

II. Feeding History

1. During infancy was your child breast fed_____, Bottle fed_____, Gastrostomy tube_____

2. Is your child's current primary nutrition taken by mouth, gastrostomy tube, or both?

_____

_____

3. Has your child's feeding experience ever been interrupted due to medical issues? Please explain:_____

_____

_____

4. What is your child's current diet? Does your child eat or refuse: purees, liquids, junior baby foods, table food, sticky foods (mashed potatoes), crunchy foods (crackers/chips), chewy foods (meats), creamy foods (yogurt), or mixed consistencies (cereal and milk)?

_____

_____

_____

5. Did your child use a pacifier? _____ For how long? _____

6. What are the foods your child will consistently eat?

_____

_____

_____

7. How often are new foods introduced?

_____

_____

8. Please identify any feeding difficulties which your child is currently experiencing including when they began? Please be very specific.

_____
_____
_____
_____

9. Please tell me about your mealtime environment:

Who is present at each meal? _____

Where does your child sit (i.e. in your lap, highchair, booster seat, infant seat, or chair)?
_____

What environmental noises are present? (TV, siblings, street noise, etc) _____
_____

Who typically feeds the patient? (self, mother, father, etc.) _____

10. How are mealtime problems managed? Please be a specific as possible.

_____
_____
_____
_____

11. Does your child have a good appetite? _____
Have medications been used or recommended to increase your child's appetite? Yes/No Please list medications_____

12. How long does it take for your child to finish a meal?_____

13. Is your child typically alert during mealtimes? Are they active? Drowsy? Please describe:

_____
_____
_____

14. Please describe your child's mood after the meal (active, drowsy, alert, etc.):

_____
_____
_____

Patient Name: _____ Date of Birth: _____

15. Please record a five-day baseline diet (including amount, times, food, liquid, duration of meal):

	Day 1	Day 2	Day 3	Day 4	Day 5
Breakfast					
Lunch					
Dinner					
Snacks					