CHILDREN'S HEALTH

FVN
CMC77453-001NS **Rev. 4/2017**

Outpatient Therapy Services
Multidisciplinary Pediatric Feeding Addendum

DEVELOPMENTAL INFORMATION

Has your child been diagnosed with a developmental disability or as having behavioral problems? ☐ Yes ☐ No (e.g. ADD/ADHD, autism spectrum disorders, oppositional behavior, aggressive behavior, speech delay, motor delay, sensory problems, learning problems, etc.)

Date of Evaluation / Diagnosis	Type of Evaluation	Results / Diagnosis	Name of Doctor / Evaluator

Please list the approximate ages at which the child was able to:

Sit Alone		Crawl		Toilet Trained	
Walk Alone		First Words		Spoke Sentences	
Walks with Support		Squats in Play		Walks Independently	

Is your child attending school, early intervention program, day care or other community activity?

Name of Facility	Date Enrolled	How Often

Please list any therapy or support services your child currently receives or has received in the past (i.e. speech therapy, occupational therapy, physical therapy, feeding therapy ABA / behavior therapy, regional center, early intervention, psychology?

Date of Treatment	Treatment Program / Therapist / Specialist	Problem(s) Addressed	Reason for Cessation of Treatment
From:_____ To: _____			
From:_____ To: _____			
From:_____ To: _____			
From:_____ To: _____			

FEEDING HISTORY

Is your child currently working with a dietitian? ☐ Yes ☐ No

Please list name, how often and goals if applicable: _____

What modes of feeding do you currently use or have used in the past?

Feeding Method	Age Introduced / how long?	Any Problems Noted / Comments
☐ Breast-fed		
☐ Bottle-fed		
☐ Finger feeds		
☐ Spoon		
☐ Fork		
☐ Knife		
☐ Straw drinking		
☐ Sippy cup		
☐ Open cup drinking		
☐ Feeding tube: (circle one) G-tube NG tube NJ tube		
☐ Other:		

Key: G-tube = gastrostomy tube; NG tube = nasogastric tube; NJ tube = nasojejunal tube ; ABA = applied behavioral analysis ; ADD = attention deficit disorder; ADHD = attention deficit hyperactivity disorder; tbsp = tablespoon; oz = ounces; mL = milliliter; etc = and so forth; GI = gastrointestinal

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What formula(s) does your child currently take by mouth? _____

What formula(s) does your child currently take via feeding tube? _____

What is the recipe to make your formula ? _____

Amount of formula fed (ounces or calories per day/ child's weight in pounds) _____

Please describe your child's feeding schedule: _____

Please check the box that describes your child's current intake of each of the following food types:

CONSISTENCY	Does eat	Can eat	Cannot eat	Won't eat	Never tried	Comments
Regular Liquid	○	○	○	○	○	
Thick Liquid	○	○	○	○	○	
Stage 1 or 2 baby food	○	○	○	○	○	
Food prepared in blender	○	○	○	○	○	
Ground or Stage 3 baby food	○	○	○	○	○	
Mashed table food	○	○	○	○	○	
Chopped table food	○	○	○	○	○	
Regular table food	○	○	○	○	○	
Crisp food (crackers)	○	○	○	○	○	
Chewy food (meat)	○	○	○	○	○	
Crunchy food (carrot)	○	○	○	○	○	

Please list various foods, flavors, textures that are favorite / easy or dislikes / difficult:

Favorite / Preferred / Easy	Dislikes / Refuses / Difficult

How does your child let you know he / she is hungry? _____

Who usually feeds your child? _____

Which other individuals can feed your child? What is their relationship to your child? _____

Where is the child usually fed?

○ Lap ○ Table / Chair ○ High chair ○ Stand / Room
○ Infant seat ○ Floor ○ Couch ○ Other _____

Describe the environment / location: _____

How long do meals typically last? _____

How much food is your child able to finish in a typical meal? _____

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Please check any behaviors that are of concern to you. Please circle the behavior(s) most concerning to you.

- ☐ Eats too fast
- ☐ Eats too much
- ☐ Refuses to open mouth
- ☐ Spits out food
- ☐ Turns away from food
- ☐ Refuses to swallow food
- ☐ Sneaks or steals food
- ☐ Eats non-food items
- ☐ Uses a bottle
- ☐ Reflux
- ☐ Eats too little
- ☐ Fails to chew food
- ☐ Gags
- ☐ Other: _____
- ☐ Vomits
- ☐ Drools
- ☐ Messy eater
- ☐ Leaves table
- ☐ Eats too slow
- ☐ Other: _____
- ☐ Pushes food away
- ☐ Fails to suck
- ☐ Throws or drops food
- ☐ Cries or tantrums
- ☐ Plays with Food
- ☐ Picky- eater
- ☐ Other: _____

Please check any techniques that you have used to get your child to eat. Please circle the behavior(s) most concerning to you.

- ☐ Threaten
- ☐ Coax
- ☐ Offer reward
- ☐ Send to time-out
- ☐ Forced feeding
- ☐ Change food offered
- ☐ Distract with play / toys
- ☐ Change meal schedule
- ☐ Model
- ☐ Spank
- ☐ Praise
- ☐ Use TV/ Video
- ☐ Limit foods
- ☐ Offer small meals
- ☐ Ignore
- ☐ Other: _____

What are your goals for therapy? (check all that apply)

- ☐ Increase amount of food
- ☐ increase variety of foods
- ☐ Improve mealtime behaviors
- ☐ Increased weight
- ☐ Decrease / eliminate tube feeds
- ☐ Tolerance of textured food
- ☐ Improve oral motor skills
- ☐ Other: _____
- ☐ Decrease vomiting related to eating
- ☐ Resolve reflux or other GI issues
- ☐ Decrease gagging during eating
- ☐ Other: _____

ADDITIONAL COMMENTS

Please list any additional information you feel is important to the evaluation and treatment of your child: _____

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Developmental Addendum

Name:	**Date of Birth:**

3 Day Food Log

In order to provide an accurate diet record It Is Important to follow these guidelines:

Specify the type of food whenever possible (brand names, % milk, etc.)
Pizza → 1 slice, medium Pizza Hut, cheese pizza; crackers → graham crackers
Include the amount of food given/eaten in measurable quantities (cup, fluid ounce, tablespoon, 1 slice, etc.)
5 Bites → 2 tsp; Handful → 1/2 cup
Describe how the food was prepared (grilled, fried, scrambled, 1 tsp oil added, etc.)
Chocolate milk → whole milk w/2 TBS chocolate syrup; Sandwich → 1 slice bread w/1 TBS peanut butter
Try your best to record each meal/snack after it Is eaten, it is much more accurate this way
* Send food record 2 weeks prior to appointment to the appropriate address*
After completion of your child's food record, a nutrient analysis will be completed by a dietitian •
****SEE SAMPLE BELOW*****

Mealtime	Type of Food (include preparation -fried, baked, oil added, pureed etc.) pureed, etc.)	Brand Name (if applicable)	How much offered (Please use measurements - 1cup, 1 tsp, 2 oz package, etc.)	How much eaten (Record measurable volumes: %, TBSP, items, mL, etc.)	Place H=Home A=Away S=School T=Therapy	Comments
DATE: 01/01/01	Day 1					
7:30 am	100% Wheat toast w / 1 tsp margarine	Pepperidge Farm w / Smart Balance	1 slice	3/4 slice	H	Happy, ate normal amount
	Peanut Butter	Skippy - natural	1 tbs	1 tsp		
	Banana		1/2 med. size	25 %		
	Chocolate milk, ready-to-drink, low fat	Nesquik	4 fl. oz	2 fl. oz		Typically consumes 4 oz.
10:00 am	Yogurt, strawberry	Yoplait, original	6 oz	2 TBS	A	Distracted, below normal amount
	Chewy chocolate chip granola bar	Quaker	1 bar	10 %		Gagged, then refused
	Apple juice	Minute Maid	200 mL	45 mL		Drinks from straw
	Crackers, cheddar	Goldfish	1/4 cup	5 fish		Preferred food
12:00 pm	Mac & cheese, prepared w / water & 1 tap butter	Easy Mac	2 oz	10 %	T	Recently added butter to increase calories
	Mandarin oranges, in light syrup, drained	Del Monte	1 fruit cup	2 slices		New food
	Hot dog (beef frank), no bun	Oscar Mayer	1	2 quarter sized slices, 1/2 thick		Eats plain - no ketchup, etc.

Mealtime	Type of Food (include preparation -fried, baked, oil added, pureed etc.) pureed, etc.)	Brand Name (if applicable)	How much offered (Please use measurements - 1cup, 1 tsp, 2 oz package, etc.)	How much eaten (Record measurable volumes: %, TBSP, items, mL, etc.)	Place H=Home A=Away S=School T=Therapy	Comments
DATE:	Day 1					

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DATE	Day 2					

Mealtime	Type of Food (include preparation -fried, baked, oil added, pureed etc.) pureed, etc.)	Brand Name (if applicable)	How much offered (Please use measurements - 1 cup, 1 tsp, 2 oz package, etc.)	How much eaten (Record measurable volumes: %, tbsp, items, mL, etc.)	Place H=Home A=Away S=School T=Therapy	Comments
DATE	Day 3					

Signature of Parent / Legal Guardian ______________ Print Name ______________ Date ______________ Time ______________

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