Mankato Clinic
Children's Health Center

Feeding Clinic
Mankato Clinic Children's Health Center
Evaluation Packet

Please complete the following forms being as detailed as possible. If a question does not apply to your child, please indicate N/A.

Identifying Information

Child's Name:_____ Date:_____

Parent(s) Name(s):_____

Other Direct Caregivers:_____

Person completing this form:_____ Relationship to Child:_____

Child's diagnosis (if applicable):_____

Diagnosis made by and diagnosis date:_____

Primary Provider's Name:_____ Clinic:_____

Names of other doctors/specialists involved with your child:_____

Name of School or Daycare:_____

Please describe your child's family/home life including those living in the home, siblings, pets, etc.:

_____

_____

Medical/Developmental History

Please list current/regular medications: -

_____

Allergies/Precautions/Restrictions:_____

Please indicate if your child has a history of any of the following:

	Yes	No		Yes	No
Was pregnancy full term?			Ear Infections?		
Any medications taken during pregnancy?			Ear tubes?		
Any complications with delivery?			Needs hearing aids?		
Any special care required at birth (i.e. oxygen, intubation)			Hearing evaluation completed? When?		
Any diagnosed genetic disorder?			Need for eye glasses?		
Is your child adopted?			History of car sickness?		
Frequent colds, respiratory infections, asthma or sinus problems?			Serious illness or injury?		
Sleeps too little			Any medical testing (i.e. MRI, EKG)?		
Sleeps too much			History of seizure(s)?		

Does your child currently receive any therapy services? (Please List Specific Services)

Therapy	Frequency	Location
☐ Speech/Language	_____	
☐ OT	_____	
☐ PT	_____	
☐ Other	_____	

Feeding History

What is your primary concern? (Check all that apply)

- ☐ Not eating enough variety
- ☐ Eating too much
- ☐ Poor growth
- ☐ Gagging
- ☐ Avoiding whole food groups
- ☐ Only eating certain kinds of foods (smooth, lumpy, crunchy, etc.)
- ☐ Aspiration
- ☐ Diarrhea
- ☐ Constipation
- ☐ Food refusal
- ☐ Transitioning from tube to oral feeding
- ☐ Vomiting
- ☐ Only eating purees
- ☐ Only drinking fluids
- ☐ Choking on Foods
- ☐ Toothbrushing intolerance
- ☐ Difficulty with temperature of foods/liquids (hot or cold)
- ☐ Other:_____ _____

When did you first notice your child had difficulty eating? _____

As a newborn, was your child bottle fed/breast fed/tube fed?_____

If applicable, what type of bottle is used? What type of nipple is used? _____

How do feedings go? (i.e. refusal, gagging, vomiting, etc.) _____

_____

If bottle or tube fed, what is being offered (i.e. breastmilk, formula): _____
Which formulas have been tried or were tried first?_____
At what age was your child introduced to the following, and is your child still using these?

- ☐ Baby cereal_____
- ☐ Baby food_____
- ☐ Finger foods_____
- ☐ Table foods_____
- ☐ Pacifier_____
- ☐ Thumb sucking_____

How does your child currently receive liquids? What kinds? _____
_____

Has your child ever needed alternative means of nutrition via a tube: _____

Concerning your child's current mealtime:

a) Who typically feeds your child?_____
b) Who typically eats with your child?_____
c) What type of chair is used?_____
d) Are there any adaptations used to help your child maintain a correct sitting position (e.g., bolster seat, seat insert, chest strap, lap tray, head support, hip strap)?_____
e) How long are meals typically?_____
f) Describe any utensils or special cups/bowls your child uses:_____
_____
g) Do you allow your child to get messy during meal time? If yes, does your child enjoy being messy? _____
h) Describe any negative reactions associated with hand and face washing:_____
_____
i) Are there any other activities going on at meal time? What activities (describe)? _____
_____
_____
j) If your child attends daycare, does their feeding differ?_____

Please note any of the following behaviors that your child exhibits during feeding:

- ☐ Gets tired easily
- ☐ Vomits during feeding
- ☐ Cries during feeding
- ☐ Tantrums
- ☐ Poor appetite
- ☐ Vomits after feeding
- ☐ Leaves the table
- ☐ Chokes on food being offered
- ☐ Purposeful spitting
- ☐ Refuses bites offered
- ☐ Chews but does not swallow
- ☐ Loses lots of food out front of mouth
- ☐ Eating time is stressful for child/parent
- ☐ Holds food in his/her mouth
- ☐ Acceptance of new foods
- ☐ Other:_____

Please describe other concerns about your child's behavior or emotional condition:_____
_____

What is your child's response when presented with a new food or a food he/she dislikes?_____
_____

If the smells of certain foods bother your child, please describe which foods and his/her reaction:_____
_____

Are there any foods that your family does not eat due to cultural, religious, or personal beliefs?_____
_____

Describe your child's snack routine (e.g., on-the-go, grazing, set time, etc.):_____
_____

How do you know if your child is hungry?_____

What are your goals for your child during feeding therapy?_____
_____
_____
_____

Please note any other information you think is applicable:_____
_____
_____
_____

3 Day Diet History Form

Please fill out this 3 Day Diet History Form completely. List the time of day food or liquid is offered (by mouth or tube), what that food or liquid item is (if brand specific, include brand), and the volume your child ingested. Please use specific measurements such as 2oz of puree, ¼ cup of pasta, or ½ of a baby carrot, rather than subjective ones such as a handful of cereal, five spoonfuls of pasta, or six sips of milk.

Day One:

			(For children with a feeding tube)	
Time of Feeding	Food Item Offered and Amount	Amount Eaten/Consumed	Gravity or Pump	Over what time period or rate

Day Two:

			(For children with a feeding tube)	
Time of Feeding	Food Item Offered	Amount	Gravity or Pump	Over what time period or rate

Day Three:

			(For children with a feeding tube)	
Time of Feeding	Food Item Offered	Amount	Gravity or Pump	Over what time period or rate

Food Inventory

Instructions: Check off any foods that your child will easily accept as part of his or her daily diet. Indicate in the column behind the food if your child will only accept specific brands or methods of preparation. (Example: only eats Hunts ketchup, Ragu spaghetti sauce, or raw carrots).

Fruits/Vegetables:

X	(Example) Carrots	Only eats raw carrots
	Apples	
	Applesauce	
	Bananas	
	Blueberries	
	Cantaloupe	
	Fruit Cocktail	
	Grapes	
	Honeydew	
	Kiwi	
	Mandarin Oranges	
	Mango	
	Nectarines	
	Oranges	
	Papaya	
	Pear Sauce	
	Pears	
	Peaches	
	Pineapple	
	Plums	
	Raspberries	
	Strawberries	
	Watermelon	

X	(Example) Celery	Only with peanut butter
	Beets	
	Broccoli	
	Carrots	
	Celery	
	Corn	
	Cucumber	
	Fruit Roll-ups	
	Green Beans	
	Kohlrabi	
	Lettuce	
	Mushrooms	
	Peas	
	Pickles	
	Radishes	
	Spinach	
	Squash	
	Sweet Peppers	
	Tomato	

Comments:

Beverages:

	Boost/Ensure or Diet Supplement	Almond Milk		Water	
	Chocolate Milk	Milk		Tea	
	Flavored Water	Milk Shakes		Yogurt Smoothies	
	Kool-Aid	Orange Juice		Soy Milk	
	Hot Chocolate	Pop		Sport Drink	
	Juice		**Comments:**		

Protein:

X	(Example) Hamburgers	Only eats burgers from McDonalds
	Bacon	Ground Beef
	Bologna	Ham
	Cheese	Hamburgers
	Chicken	Hotdogs
	Chicken nuggets	Ice Cream
	Cottage Cheese	Jell-o
	Eggs	Milk
	Fish	

	Nuts	
	Pork Chops	
	Pudding	
	Roast Beef	
	Roast Pork	
	Sausage	
	Steak	
	Tuna Fish	
	Yogurt	

Comments:

Starches:

X	(Example) Cereal	Only eats Fruit Loops
	Bagels	
	Baked Potatoes	
	Bread	
	Cake	
	Dry Cereal	
	Hot Cereal	
	Chips	
	Cinnamon/Sugar	
	Cookies	
	Crackers	
	Danish/Donuts	

	English Muffins	
	French Fries	
	French Toast	
	Home Fries	
	Mashed Potatoes	
	Noodles/Pasta	
	Pancakes	
	Popcorn	
	Pretzels	
	Rice	
	Tatar Tots	
	Toast	
	Tortilla Shells	

Comments:

Purees:

X	(Example) Ketchup	Only eats hunts ketchup
	Barbeque Sauce	
	Blue Cheese Dressing	
	Cream Cheese	
	French Dressing	
	Honey Mustard	
	Italian Dressing	
	Jelly/ Jam	
	Ketchup	
	Mustard	
	Peanut Butter	

	Ranch Dressing	
	Salad Dressing / Mayonnaise	
	Sour Cream	
	Soy Sauce	
	Sweet and Sour Sauce	
	Syrup	
	Thousand Island Dressing	
	Vinaigrette Dressing	

Comments:

Mixed Texture Foods:

X	(Example) Pasta and Cheese	Only eats Kraft Mac and cheese
	Cereal with Milk	
	Cheese Sandwich	
	Chili	
	Coleslaw	
	Deli Sandwich	
	Hot dish	
	Lasagna	
	Loaded Baked Potato	
	Nachos with Cheese Sauce	
	Pasta with Cheese	

	Pasta with Tomato Sauce	
	Peanut Butter & Jelly Sandwich	
	Pizza	
	Potato Salad	
	Quesadillas	
	Soups/Stews	
	Tacos	
	Vegetables with cheese sauce	

Comments: