

Does your child communicate in order to (check all that apply)

____ ask for wants/needs

____ ask questions/make requests

____ seek your attention

____ greet people

____ ask for help

____ share information

Describe mother's general health during pregnancy (illnesses, accidents, medications):

Was the child full term or premature? _____

Did your child spend time in NICU (if yes, how long?) _____

Any problems at birth or during first 2 weeks (jaundice, anoxia, weight, etc.):

Provide approximate age for the following illnesses, operations, conditions, and/or diagnoses?

Earaches: _____

Asthma: _____

Seizures: _____

Tonsillitis: _____

Chronic colds: _____

Tonsillectomy: _____

Head injuries: _____

Adenoidectomy: _____

Chicken Pox: _____

Cleft Palate/Lip: _____

Pneumonia: _____

ADHD: _____

Influenza: _____

Meningitis: _____

GI Issues: _____

Sinus Problems: _____

Feeding Disorder: _____

Cancer: _____

Diabetes: _____

Traumatic Brain Injury: _____

List any surgeries, hospitalizations, and/or accidents:

List any medications taken by your child: _____

What is the child's current overall health status? _____

Does child have any medically diagnosed conditions or genetic syndromes? _____

Provide approximate age for the following:

Sat independently	
Crawled	
Walked unaided	
Babbled	
First meaningful word	

If so, please describe: _____

Has your child ever received VFSS/MBS/FEES (swallow study)? If so, report results: _____

Does your child feed themselves _____ independently or _____ with assistance:

Does your child use utensils _____ independently or _____ with assistance:

Does your child require special positioning during mealtimes? _____

Does your child enjoy mealtimes? _____

Choose which method used for liquid consumption:

- _____ Bottle fed
- _____ sippy cup (what kind?)
- _____ open cup
- _____ straw
- _____ water or sports bottle

Check the kinds of food your child eats:

- _____ smooth purees
- _____ purees with lumps or textures
- _____ fork mashed
- _____ Food cut up into bite sized pieces
- _____ regular table foods without modifications

Check if your child exhibits any the following:

- | | | |
|---|-------------------------|-------------------------------|
| _____ Choking during meal (specific food or liquid) | _____ gagging | _____ difficulty chewing |
| _____ coughing during meals | _____ food refusals | _____ holding food in mouth |
| _____ wet or gurgly voice during or after eating | _____ mouth sensitivity | _____ stuffing mouth too full |

Do certain foods or liquids appear to be more difficult to consume? _____

List any adaptative feeding equipment used (chairs, utensils, cups): _____

Does child look at family members when they are named? _____

Does child point to common object _____

