



# Center for Therapeutic Intervention

## **FEEDING INTAKE FORM**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Therapist:** \_\_\_\_\_

### **Primary concern(s) include:**

- Gagging/coughing on textures
- Limited volume/not eating enough
- Slow weight gain
- Vomiting
- Choking
- Eats very limited diet/selective
- Refuses to swallow/holds food in mouth
- Difficulty swallowing
- Refusal to eat
- Easily distracted when eating
- Other: (specify, or describe problem(s) checked above if helpful)

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Feeding concerns began when child was \_\_\_\_\_ years old.

### **Parent's primary method of handling child's feeding issues included:**

- Distraction during meal (games, toys, TV, etc...)
- Compensating for lack of eating by allowing child to drink more liquids
- Feeding child upon request throughout the day
- Supplementing diet with high calorie supplements or formula



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- Force feeding when necessary
- Giving only preferred foods
- Altering the environment (dimming lights/eliminating noises/putting on music/Other:\_\_\_\_\_)
- Other: (Specify/describe) \_\_\_\_\_

## Feeding in the Home Environment:

**Location of meals:**  kitchen  dining room  living room  eats “on the go”

other:\_\_\_\_\_

**Does the child:**  eat alone  with the family

### Typical Response to New/non-preferred foods:

cooperative /compliant  verbal refusal  turns/walks away  pushes food away

purses lips/clenches jaw  gagging  vomiting  crying  throws food  tantrums

anxiety response  only eats preferred foods  other: \_\_\_\_\_

**Typical length of mealtimes:**  0-5 minutes  5-15 minutes  15-20 minutes

20-30 minutes  greater than 30 minutes

**Mealtime Routine:**  established  not established

Describe:\_\_\_\_\_



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## **PREFERRED and NON-PREFERRED FOODS**

<b>Preferred:</b>	<b>Non-Preferred:</b>



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