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Lauren Ramos, A.P.R.N.
Kelly Caseber, A.P.R.N.
Jessica Albaugh, A.P.R.N.
Kelly Stryjewski, A.P.R.N.

Dear Parent:

Having a child who does not feed well is a worrisome, frustrating, confusing and at times, a medically concerning problem. We understand how complex feeding difficulties can be, and we are all committed to helping you and your child identify what is interfering with your child's eating and how to improve their growth and interactions with food.

In order to best help us prepare for your child's evaluation, we would like you to carefully read over the following information and to complete the enclosed forms. Please complete the forms in as much detail as possible. Many items on the forms can be simply answered by checking YES or NO in the appropriate space. If you give a YES response, please explain this answer thoroughly in the space provided or on the back of the page.

Please return your completed forms by mailing or emailing them. **Once we receive these forms, we call you to schedule your evaluation.** Our mailing address is: 2901 58th Ave N., St. Petersburg, FL 33714; or email them to: feedingtherapy@pedgi.org

THE FEEDING APPOINTMENT:

On the day of your appointment, the Evaluator will be observing your child, yourself and preferably all other major caretakers having a snack together. We would like you **to bring at least 2-3 foods of different textures and 1 drink that your child will most likely eat, and at least 1-2 food(s) your child will most likely refuse.** We want to be able to evaluate your child's current skill level with foods that they do well with, as well as determining how they handle more challenging foods. The goal of the evaluation is to see if your child would benefit from Feeding Therapy services. You will get some strategies, but the majority of strategies will come from ongoing Feeding Therapy services if your child qualifies.

Please also **pack your child's preferred utensils, cup, bottles and dishes** to make the assessment situation as "home-like" as possible. We find it helpful to explain to older children that you are packing a "picnic" to eat together at the Doctor's office, and that these doctors' job is to help children and families learn to eat better together. We would also ask that that you **NOT feed them for at least 1 ½ hours before** their scheduled appointment time.

A final copy of the report will be sent to you and your child's physician, sometime during the following 4 weeks.

On the day of your appointment, please bring your insurance card for us to copy so that we can properly submit the claim for you.

If you have any questions about this information or the forms you are to complete, please feel free to call us at 727-822-4300.

Child's Name (First and Last): _____

Child's Date of Birth: _____

Today's Date: _____

Child's Pediatrician: _____

Please answer as completely and accurately as possible.

Are there any medical precautions the therapist should be aware of when working with your child?

PEDIATRIC FEEDING HISTORY FORM

1. Please explain, in your own words, what your child's current feeding problem is:

2. Was your child breast fed? From when to when _____

   Was your child bottle fed? From when to when _____

Please describe your child's initial skill on the breast and/or bottle:

3. During these early feedings, did your child frequently arch, cry, spit up, gag, cough, vomit or pull off the nipple? Circle the behaviors shown and describe when they would happen, and why, and for how long:

4. If your child is still taking the bottle, what type of bottle? How many ounces? What type of formula? Any formula changes?

5. Describe how the weaning process off the breast and/or bottle went and why the child was weaned:

6. At what age was your child introduced to Baby food? _____Finger foods? _____ Table food? _____

When did they Transition fully to table food? _____

Please describe how these transitions were handled by your child, especially if any difficulties happened:

IF YOUR CHILD EATS BY MOUTH, PLEASE ANSWER THE FOLLOWING QUESTIONS:

6a. List the foods that your child currently will eat and drink (put a star next to their favorites). Please be specific and include as many as possible:

6b. List the foods your child refuses:

6c. List the foods your child is allergic to:

6d. Describe your child's mealtime:

Who typically feeds your child? _____

Who typically eats with your child? _____

What type of chair is used? _____

How long are meals typically? _____

Does your child use utensils or any type of special cups/bowls (describe)? _____

Are there any other activities going on at meals? What activities (describe)? _____

6e. What times does your child typically eat and what type (bottle, breast, solids)?

Time	Breast	Bottle	Solids (baby food; table?)

IF YOUR CHILD IS *TUBE FED*, PLEASE ANSWER THE FOLLOWING QUESTIONS:

7a. What type of formula is used and exactly how do you mix it?

7b. Describe where your child is tube fed and what activities are occurring at the same time:

7c. Describe your child's reactions to the tube feedings (connecting, during, disconnecting):

7d. Please detail your child's feeding schedule below.

Time of feeding (start time)	NG, G or Continuous	Amount	Gravity or Pump	Over what time period or what rate

*PLEASE ANSWER FOR ALL CHILDREN

8. Has your child ever been on any type of special diet other than what you just described (circle 1)? **YES NO**
   If yes, please describe type of diet, at what ages, why and what was your child's response:

9. How do you know your child is hungry or full?
   Hungry?

   Full?

10. Has your child lost or gained any weight in the last 6 months, and how much?

11. Would you describe your child's weight as (circle one): Ideal Underweight Overweight

12. Does your child have/had any of the following problems (circle which ones)? Please describe:
    Dental, frequent constipation, frequent diarrhea, vomiting, choking, gagging, coughing

13. Does your child take a vitamin supplement? Which one?

14. Describe how you, and your child feel after a feeding:
    You:

    Your child:

15. What other evaluations have been completed regarding your child's feeding difficulties and what were the results/what were you told?

16. What treatments have been tried for this problem, and what were the results?

17. How can we be most helpful to you and your child?

Developmental History

PERSONALITY PROFILE

What are your child's gifts/strengths?_____

EARLY HISTORY

Going back to the first two years of the child's life, what type of baby was he/she? (i.e. feeding, sleeping, activity level)_____

_____

Please describe your child's toddler stage:_____

_____

DEVELOPMENTAL MILESTONES

Has your child's developmental milestones been EARLY / ON TIME / LATE (circle one)? Please describe:

_____

_____

_____

VISUAL DEVELOPMENT

Has your child experienced any problems with his/her eyesight or vision? _____

AUDITORY DEVELOPMENT

Has your child experienced any problems with his/her hearing? (i.e. operations, infections, tubes placed)

_____

SENSORY and MOTOR DEVELOPMENT

Please check all that apply:

_____My child seems to be overly sensitive to sensory experiences more so than most people:
_____Auditory _____Tactile _____Visual _____Movement _____Taste _____Smell

_____My child doesn't seem to react to sensory experience as readily as most people:
_____Auditory _____Tactile _____Visual _____Movement _____Taste _____Smell

_____My child actively seeks out sensory experiences more so than most people:
_____Auditory _____Tactile _____Visual _____Movement _____Taste _____Smell

_____My child has difficulty differentiating sensory experiences. (e.g. confuses sounds, can't find objects in drawer or bag without looking, bumps into things) Please describe: _____

_____My child has trouble learning new movements.

_____My child tends to be clumsy and has balance and coordination problems.

Previous Testing and Treatments

Has your child had any previous ASSESSMENTS or TREATMENTS? **Please attach any relevant reports.**

ASSESSMENTS

	NO	YES	DATE	PLACE
Medical				
Audiological				
Speech				
Educational				
Psychological				
Occupational Therapy				
Physical Therapy				
Feeding				

TREATMENT

	NO	YES	START and END	PLACE	PROVIDER & CONTACT INFORMATION
Medical			START: END:		
Audiological			START: END:		
Speech			START: END:		
Educational			START: END:		
Psychological			START: END:		
Occupational Therapy			START: END:		
Physical Therapy			START: END:		
Feeding					