APPENDIX 9

Initial Evaluation Form

Instructions

To help with our evaluation, please provide copies of the following items:

1. The child's most recent medical evaluation or medical record.
2. The child's most recent educational and psychological evaluations, including copies of current educational programs (IEP or IFSP).
3. All programs (previous and current) designed to treat the feeding problems.
4. The child's typical daily schedule.

When you come to your appointment, please bring some food for your child to eat. Bring food your child likes and dislikes. If you are currently working with a therapist, teacher, or other provider on feeding, they are welcome to attend your child's appointment.

Today's Date: _____

Part I. Biographical

Name: _____ Date of Birth : _____

Child currently lives at (circle one): Home Institution Other

Parent's Name(s): _____ Telephone: _____

Street Address: _____ City, State, Zip: _____

Educational Service Provider: _____
(school or early intervention agency)

Address: _____ City, State, Zip: _____

Telephone: _____ Ext: _____ Fax: _____

Teacher or Therapist: _____

Child's Legal Guardian: _____

Primary Physician: _____ Phone: _____

Address: _____ City, State, Zip: _____

Part II. Feeding Information

1. Record below the feeding difficulties which are currently problematic. Include onset of each problem.

Feeding problem	When did the problem start?
_____	_____
_____	_____
_____	_____

2. Was feeding interrupted at any time in the child's history? ☐ Yes ☐ No

   For how long? _____

   For what reason? _____

3. Feeding Environment

   Check the appropriate answer.

   ☐ lap ☐ booster seat ☐ infant seat

   ☐ table/chair ☐ high chair ☐ other (please specify)

   Does the child eat alone or with the family? _____

4. Does the child have behavior problems during mealtimes? ☐ Yes ☐ No

   If yes, please specify:

   ☐ throws food ☐ messy eater

   ☐ spits food ☐ takes food from others

   ☐ cries, screams ☐ refuses food

   ☐ leaves the table before finished ☐ other (please specify)

   ☐ only eats certain foods ☐ overeats

5. What do you do when your child has behavior problems during a meal?

   _____

   _____

   _____

6. Feeding Practices

   At what age were solids introduced? _____

   Was a nipple/pacifier used during neonatal period? ☐ Yes ☐ No

   During infancy, was child fed by bottle ☐ breast ☐ combination ☐

(continues)

6. Feeding Practices (*continued*)

Food Consistency: Please check all which are applicable: (if your child could eat a food texture, but currently will not do so, mark "can eat.")

	does eat	can eat	never tried	can't eat
liquids/soups	☐	☐	☐	☐
strained baby food	☐	☐	☐	☐
junior baby	☐	☐	☐	☐
creamy foods (pudding)	☐	☐	☐	☐
blenderized table food	☐	☐	☐	☐
mashed table food	☐	☐	☐	☐
chopped table food	☐	☐	☐	☐
regular table food	☐	☐	☐	☐
crisp foods (crackers)	☐	☐	☐	☐
chewy foods (meat)	☐	☐	☐	☐
crunchy foods (celery)	☐	☐	☐	☐

Note reason for refusal of any foods.

_____

_____

_____

Describe any special diet.

_____

_____

_____

7. Meal Pattern

- Please write down a 3-day diet history on the back of one of these pages or on another piece of paper. Include everything your child has to eat or drink, approximate amounts eaten, and what time they were eaten.
- Describe a typical meal. Include the sequence in which food is offered to the child (i.e., liquids always first, etc.), what happens during the meal, and how the meal is terminated.
- Do the child's food habits and preferences match the family's? ☐ Yes ☐ No
- Does the child eat little meals and snacks throughout the day? ☐ Yes ☐ No

8. The child's appetite is best described as (circle one):

poor fair good excellent eats too much

How long does it take for the child to complete a meal? (circle one)

less than 10 minutes 10–30 minutes 30–60 minutes over 60 minutes

How does the child indicate hunger?

_____

_____

_____

9. Other information (specify preferred foods; current method parents use to handle the feeding problems, etc.).

_____

_____

_____

Part III. Medical Information

1. Diagnoses: _____

2. Current medical problems:

_____

_____

_____

3. Current medications and dosages:

_____

_____

_____

4. Does your child have any known or suspected food allergies or intolerances?

_____

_____

_____

5. Current Oral Motor Status

Answer the following questions by circling yes or no:

Does your child drool?	Yes	No
Does your child have problems with sucking?	Yes	No
Can your child bite off pieces of food voluntarily?	Yes	No
Does your child have a tongue thrust or poor tongue mobility?	Yes	No
Does your child choke or gag often?	Yes	No
Can your child keep his or her mouth closed?	Yes	No
Does your child have problems chewing?	Yes	No
Is your child hypersensitive to food textures or temperature?	Yes	No

6. Associated Feeding Problems

Estimate the frequency of occurrence for each of the following per day:

vomiting/rumination _____

teeth grinding _____

food allergies _____

coughing _____

gagging _____

grunting _____

profuse perspiration (diaphoresis) _____

aspiration _____

7. Were any of the following used during the neonatal/early infancy period?

Dates		Dates	
_____	☐ tracheotomy tube	_____	☐ NG tube
_____	☐ nasal cannula	_____	☐ other
_____	☐ gastrostomy tube		

If child is receiving tube feeds, complete relevant sections below.

Feeding tube: (Circle type)

G-tube GJ-tube NG-tube NJ-tube

What percentage of daily intake is by tube? _____

_____

Type of formula used:

_____

_____

Amount of formula fed (in ounces or cc's):

_____

_____

How feeding is done:

Continuous feeds—How much? _____ time run: _____

Bolus feeds—How much? _____ times? _____

Person who does feeds: _____

Part IV. Adaptive Behavior

1. Current Feeding Skills

☐ drinks from bottle? Special adaptation, type _____

Does child hold? _____

☐ fed by parents? How? _____

☐ feeds self with fingers?

☐ feeds self with spoon? Special adaptation, type _____

☐ Independent ☐ needs help

☐ feeds self with fork? ☐ Independent ☐ needs help

☐ uses knife? ☐ Spreads ☐ Cuts

☐ drinks from cup/glass? Special adaptation, type _____

☐ drinks from straw?

☐ pours own drink?

☐ prepares own snack?

☐ has child ever self-fed?

2. Does your child have any other behavioral or developmental problems other than feeding? (sleep problems, speech delays, behavior problems, toileting problems)

Problem and its description:

_____

_____

_____

Part V. Motivation

Please list the following:

Favorite foods: _____

_____

_____

_____

Favorite recreational materials: _____

_____

_____

_____

Favorite activities: _____

_____

_____

_____