Nevada Speech and Therapy Group

Quality In-home Speech Therapy

FEEDING/SWALLOWING

Child Name: _____

Explain your concerns regarding your child's feeding/swallowing: _____

_____

When did you first become concerned? _____

How has the condition changed since your initial concern? _____

_____

What has been done about this concern? _____

Are there differences in interactions during feeding among caregivers? Yes No

Has child attended or is currently attending any other therapies? Yes No

Which? _____

Does child refuse food? Picky Eating? Yes No

Explain: _____

_____

Does child have preferences for taste, texture or temperature? Yes No

Does child experience state/mood fluctuations during meal time? Yes No

Does child have allergens in environment (pets, smoke, etc)? Yes No

Has child been previously tube fed? Yes No

Reason: _____

_____

Does child experience reflux, vomiting, or constipation? Yes No

Does child have GERD? Yes No

Has child had a tracheotomy or been medically ventilated? Yes No

Does child experience difficulty breathing from lack of oxygen? Yes No

Does child have history of Upper Respiratory Infections or Pneumonias? Yes No

Does child exhibit difficulty managing secretions (excessive drooling)? Yes No

Does child experience coughing, choking, wet/hoarse voice? Yes No

Does child have unusual behaviors at meal time? Yes No

If you have noticed a change in your child's state or behaviors specifically at meal time, what are they? How do you respond to them? _____

_____

Does child have a routine feeding schedule? Yes No

Does child follow motor planning directions (e.g., "open your mouth")? Yes No