

Oral-Motor Feeding Evaluation
Intake

I. Biographical Information

Name: _____ Date of Birth: _____

Parents: _____

Address: _____

City, State, Zip: _____

Telephone: (h) _____ (w) _____

Educational Service Provider: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

Teacher: _____

Therapist/s: _____

Name of Primary Care Physician: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

II. Parent Interview

- Does your child have a history of choking?
- Does your child cough during mealtimes? How frequently?
- Does your child vomit while eating? How do you respond to this?
- Does your child exhibit difficulty digesting foods? Explain.

Were oral feeding interrupted at any time in the child's history?

- For how long? _____
- For what reason? _____

f. Food Consistency – Please check all that apply:

Type	Does eat	Can eat	Never tried	Can't eat
Liquids/soups				
Strained baby food				
Junior baby food				
Creamy food (ice cream, yogurt)				
Blenderized table food				
Mashed table food				
Chopped table food				
Regular table food				
Crisp foods (crackers, toast)				
Chewy foods (meat)				
Crunchy foods (carrots, celery)				

Meal Pattern

- Please write down a 3-day diet history on the back of one of these pages or on some other paper and return it with this packet. Include everything your child has to eat or drink, approximate amounts eaten, and what time they are 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?
- Does the child eat little at meals and snack throughout the day?
- How long does it take for the child to complete a meal? (circle one)

less than 10 minutes 10-20 minutes 20-30 minutes
30-60 minutes over 60 minutes

f. How does the child indicate hunger?

g. Please list all current feeding skills:

1. ___ drinks from bottle? Special adaptation, type ___
Does child hold bottle? ___
2. ___ feeds by parents? How? ___
3. ___ feeds self with fingers? Large pieces ___ small ___
Special adaptation, type ___
4. ___ feeds self with spoon? Special adaptation, type ___
5. ___ feeds self with fork? Independent ___ needs help ___
6. ___ drinks from cup/glass? Independent ___ needs help ___
Special adaptation, type ___
7. ___ drinks from other device? Special adaptation, type ___
8. ___ has child ever self-fed?

III. Medical Information

a. Diagnoses: _____

b. Current medical problems: _____

c. Current medications and dosages: _____

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

e. Associated feeding problems: Estimate the frequency of occurrence for each of the following per day:

- | | |
|-------------------------|----------------------------|
| ___ vomiting/rumination | ___ profuse perspiration |
| ___ teeth grinding | ___ aspiration |
| ___ coughing | ___ other (please specify) |
| ___ gagging | ___ drooling |
| ___ grunting | |

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

Dates

Dates

___ NG tube
___ nasal cannula
___ gastrostomy tube

___ tracheostomy tube
___ other

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

Gastrostomy tube:

What percentage of daily intake is by tube? _____

Type of formula used: _____

Amount of formula fed (cc/child's weight): _____

How is feeding done: Continuous feeds across _____ hours

Time run: _____

Bolus feeds at scheduled times _____

Person who does feeds _____

Nasogastric tube:

What percentage of daily intake is by tube? _____

Type of formula used: _____

Amount of formula fed (cc/child's weight) _____

How feeding is done: Continuous feeds _____ Bolus feeds _____

Duration _____

Frequency of tube placement _____

Person who does feeds _____

IV. Motivation

Does the child appear to enjoy social interaction? ___ Yes ___ No

Does the child enjoy verbal praise? ___ Yes ___ No

Please list:

- a. Favorite foods: _____
- b. Favorite recreational materials: _____
- c. Favorite activities: _____

