Patient's Name: ____________________________ DOB:______________________

Date:_____________________

Form completed by :____
(Name and relationship to patient)

Was your child (check all that apply)
__ breast fed
__ bottle fed
__ ate baby food
__ eats table foods

Describe any difficulties with transitions or if they struggled with any stages of foods:

____

____

____

Are they currently (check all that apply)
__ drinking from a bottle
__ drinking from a sippy cup
__ drinking from a straw
__ drinking from an open cup
__ using spoon
__ using fork

Mealtime behaviors (check all that apply):
__ Coughing
__ Choking
__ Spit up
__ Vomit
__ Turns head
__ Pushes food away
__ Runs away
__ Cries
__ Arches

Diagnosed with
__ reflux
__ constipation

Medications:

Allergies:

Any of the following (check all that apply)
__ Tongue tie
__ Lip tie
__ Cheek tie

Revised
__ Yes
__ No

Has your child had previous feeding therapy with
__ ST
__ OT
__ N/A

Happy with the current amount of intake?
__ yes
__ no

Have you had a swallow study done?
__ yes
__ no