Stepping Stones

ABA

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FEEDING DISORDERS INTAKE FORM

Instructions:
This form is to be completed in reference to feeding issues. Please complete and submit this screening form or provide the form during initial intake to your BCBA/ BCaBA:

E-mail: kscott@steppingstonesaba.com
Phone: 919-922-7561
Fax: 919-400-4224

You will need to bring the following additional information to the evaluation.

1. Your child's most recent medical evaluation and medical records.
2. Records of therapy (previous and current) for your child's feeding difficulties.
3. A current videotape sample of a "typical" mealtime with your child (if available).

BIOGRAPHICAL

Child's Name:_____ Date of Birth: _____

Caregiver/Legal Guardian

Name: _____

Address: _____

City, State, Zip: _____

Telephone:_____(Home) _____(Work)

_____ (Cell)

CURRENT MEDICAL PROVIDERS

Name of Primary Care Physician: _____

Affiliation: _____

Address: _____

Telephone: _____

Name of Gastroenterologist: _____

Affiliation: _____

Address: _____

Telephone: _____

PRIOR PROFESSIONAL CONTACTS

Please list all past and current therapies your child has received by completing each of the boxes below.

Service	Start/ End Date (Month / Year)	How Often?	Length of each therapy session	Did therapy focus on feeding?	Effect of therapy for feeding problem	Therapist Information (Name, address, telephone)
☐ ***Occupational Therapy*** ☐ Yes ☐ No		☐ 1x/ month ☐ 2x/ month ☐ 1 x / w e e k ☐ 2 x / w e e k ☐ 3 x / w e e k _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs _____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	
Physical Therapy ☐ Yes ☐ No		☐ 1x/ month ☐ 2x/ month ☐ 1 x / w e e k ☐ 2 x / w e e k ☐ 3 x / w e e k _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs _____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	
Speech ☐ Yes ☐ No		☐ 1x/ month ☐ 2x/ month ☐ 1x/ week ☐ 2x/ week ☐ 3x/ week _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs _____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	
Early		☐ 1x/	☐ 15 min	☐ Yes	☐ Worse	

Intervention Yes No		☐ month ☐ 2x/ month ☐ 1x/ week ☐ 2x/ week ☐ 3x/ week _____	☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs _____	☐ No	☐ No change ☐ Improved	
Nutrition Yes No		☐ 1x/ month ☐ 2x/ month ☐ 1x/ week ☐ 2x/ week ☐ 3x/ week _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs _____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	
Others: (please list)		☐ 1x/ month ☐ 2x/ month ☐ 1x/ week ☐ 2x/ week ☐ 3x/ week _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs _____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	

MEDICAL INFORMATION

Birth History

How many weeks pregnant were you when your child was born? _____
Was your child born by vaginal delivery or C-section? _____
What was your child's birth weight/length?_____lbs_____
csm Was your child's stool passage within the first 24 hours? _____
Were there any problems at birth? _____
Were there any problems during pregnancy? _____

Family

(E.g., colitis, inflammatory bowel disease, ulcerative colitis, Crohn's, colon polyps, colon cancer, celiac disease, irritable bowel syndrome, allergies, asthma, thyroid, liver, diabetes, mental health issues, or other medical conditions)
Please list: _____

_____

Gastrointestinal Symptoms

Trouble swallowing	Yes	No _____
Nausea or vomiting	Yes	No_____
Vomiting blood or bile	Yes	No_____
Appetite change	Yes	No _____
Heartburn	Yes	No _____

Abdominal Pain: (If your child does not have abdominal pain, write N/A for the first question and go on to the next section)
How long as your child had abdominal pain? _____
How often does it happen? _____
At what time of day does it happen? _____
How long does the pain last? _____
Any pain at night when sleeping? _____
Is the pain better or worse with food? _____
What type of food affects the pain? _____
Does the pain improve with a bowel movement? _____
How much school is missed because of the pain? _____

Bowel History

Is your child toilet trained? _____
Does your child wet the bed?_____
How often does your child have stools? _____
Are the stools: ☐ Hard formed ☐ soft formed ☐ pudding, or ☐ watery
Do the stools vary in consistency? _____

Does your child take laxatives to stool? _____
Does your child have accidents in his or her underwear? _____
Does your child exhibit any stool withholding behavior?_____
Any blood in the stools?_____Any black/tarry stools? _____
Any mucous in the stools? _____

Other GI
Liver disease _____
Gallbladder disease _____
Jaundice_____
Irritable bowel disease _____
Inflammatory bowel disease_____

Medical History
Current Diagnoses: _____
Previous Illnesses: _____
Past surgeries/hospitalizations: _____
Current medications and dosages: _____
_____
Allergies: Medications/Environmental/Seasonal _____
Allergies: Food_____
Food Intolerance? (e.g. lactose intolerance) _____
Are immunizations up-to-date?_____
_
If not up-to-date, what is delinquent? _____
Any developmental concerns? _____

Review of Systems
General
Weight loss ☐ Yes ☐ No
If yes, how much?_____lbs. over what period of time did this weight change occur? _____
Weight gain ☐ Yes No
If yes, how much?_____lbs. over what period of time did this weight change occur? _____

☐
☐
Unexplained fevers Yes No Unusual fatigue Yes NoPoor appetite Yes No
Poor sleeping Yes No
☐
☐

Skin
Eczema ☐ Yes ☐ No
Rashes ☐ Yes ☐ No

Ear, Nose & Throat

☐
☐
Frequent ear infections Yes No Sores in mouth Yes NoSinus problems Yes No
☐
☐

Respiratory

☐
☐
☐
☐
☐
☐
Pneumonia Yes NoAsthma/wheezing Yes No
Chronic cough Yes No

Neurologic Seizures Yes No
Frequent headaches Yes No
Migraine headaches Yes No
Unusual/excessive fussiness/irritability Yes No

Endocrine Diabetes Yes No
Thyroid Yes No
Growth problems Yes No

FEEDING HISTORY

Was there a time when you did not or were not able to give your child food or liquid by mouth?
☐ Yes ☐ No
How long?_____How old was your child at the time?_____
Why? _____
Has this problem since been resolved? ☐ Yes ☐ No If yes, when was it resolved? _____

Medical Tests
Please check if your child has had the following tests below. Write down the date (as best you can remember) when the test was done.

TEST	DATE
☐ MBS/OPMS/VFSS (swallow study)	
☐ Endoscopy	
Gastric Emptying	
pH probe	
☐ Upper GI	

Tell us if your child has had or has any of the following:

	HAD	HAS NOW
Tracheostomy	☐	☐
Nasal cannula	☐	☐
OG-tube	☐	☐

NG-tube	☐	☐
G-tube	☐	☐
J-tube	☐	☐

Tube Feeding *(if applicable)*
Formula Type:_____
Tube Feeding Schedule:

Time	Amount	Method (Pump, Gravity, Bolus)	Rate

If your child consumes oral feedings in addition to his/her tube feedings, please complete the "Meal Pattern" section below.
Does your child have a special diet? ☐ Yes ☐ No
If yes, what is it? _____
Your child's appetite is best described as (check one): ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Eats too much
Does your child tell you when he/she is hungry? ☐ Yes ☐ No
How? ☐ Tells me what he/she wants ☐ Points at food/cabinet/refrigerator ☐ Goes and gets food/can/package ☐ Cries ☐ Takes me to the cabinet/refrigerator
Other: _____

Meal Pattern
Give us an example of when, where, what, & how much your child eats at each meal.

Meal	**Time**	**Location**	**Food & Approximate Amount**
Breakfast			
AM Snack			
Lunch			
PM Snack			
Dinner			
Other Snack			

Height:____cm____ Weight:_____lbs. List the date when these measurements were taken: _____
Where were these measurements taken? ☐ Pediatrician's Office ☐ Other clinic/medical facility ☐ Home (PLEASE SEND A GROWTH CHART FROM YOUR PEDIATRICIANN'S OFFICE WITH GROWTH MEASUREMENTS FROM BIRTH, IF POSSIBLE.)

Chronology
As an infant, my child
☐ was Bottle fed ☐ Breast fed ☐ Both ☐ Neither

☐
When bottle or breast fed, my child Drank very littleDrank about half of what he/she was supposed to Drank most of what he/she was supposed to

Tell us how old your child was (write the age in the column labeled “Child’s age”) when you first started feeding each of the foods listed under “type of food” and tell us how your child reacted (“refused” or “accepted”) to each type of food. For example, if you started cereal at 6 months, write 6 months under “child’s age,” next to the line with the word “cereal” in it, then check whether your child “refused” or “accepted” the cereal.

CHILD’S AGE	TYPE OF FOOD	CHECK ONE	
	Cereals	Accepted	Rejected
	Baby food	Accepted	Rejected
	Mashed food	Accepted	Rejected
	Table food	Accepted	Rejected

CURRENT FEEDING BEHAVIOR

Right now, my child eats in a
Regular chair Booster seat High chair My lap Other:_____.
During meals, my child eats with the rest of the family does not eat with the rest of the family.

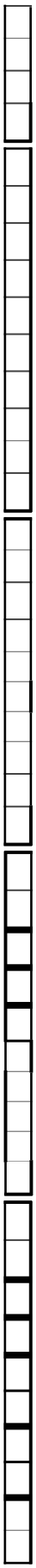
How long does it take for your child to eat a meal? (Check one.) Less than 10 minutes10-20 minutes
20-30 minutes
30-40 minutes
40-60 minutes
More than 60 minutes

Current Feeding Skills

Check the one(s) that describe your child.Drinks from bottle Drinks from cup/glass
Fed by caregiver Drinks from straw
Feeds self with fingers Pours own drink
Feeds self with spoon Prepares own
snack Feeds self with fork
Uses knife

Tell us about what your child does and does not eat RIGHT NOW. You may check more than one box for

each food. DOES EAT means that your child will eat the food most of the time when you serve it.
CAN EAT means that your child has the skill or ability to eat the food (even if he/she does not eat it).
NEVER EATS means that your child never or rarely will eat the food when you serve it.
CAN’T EAT means that your child does not have the skill or ability to eat the food even if he/she is willing to eat it. HAS NOT TRIED means you have never given the food to your child.



Does eat

Can eat
Never
eats
Can’t eat
Has not
triedLiqu
ids Baby
food
Creamy foods (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)

Does your child's food habits and preferences match the family's? ☐ Yes ☐ No Does your child eat little meals and snacks throughout the day? ☐ Yes ☐ No

ORAL MOTOR BEHAVIOR

My child had or has the following problems (Check all that apply):

PROBLEM	HAD	HAD NOW
Drooling	☐	☐
Poor suck	☐	☐
Can't bite off pieces of food	☐	☐
Difficulty with tongue control (tongue thrust, poor mobility)	☐	☐
Difficulty swallowing	☐	☐
Difficulty with lip control (can't keep his/her mouth closed)	☐	☐
Difficulty chewing (for children over 12 months)	☐	☐
Over sensitivity to food textures, temperatures, spoon	☐	☐
Vomiting/Rumination	☐	☐
Teeth grinding	☐	☐
Coughing with certain food/drinks	☐	☐
Gagging with certain food/drinks	☐	☐
Grunting	☐	☐
Profuse perspiration (diaphoresis)	☐	☐
Aspiration	☐	☐
Other: _____	☐	☐

OTHER BEHAVIORS

Sleep

Check any that describe your child.

☐ Has difficulty going to sleep at
☐ night Tantrums when put to bed
☐
☐
☐
☐
☐
Has other behavior problems when put to bed Has difficulties going to sleep during napsHas difficulties staying asleep Has difficulties staying in bed Wants to sleep in caregiver's bed

My child goes to bed at_____pm.

My child wakes up at_____am.

My child takes a nap from_____ to_____and_____to_____.

OTHER BEHAVIOR PROBLEMS

Does your child have any other behaviors that you think are a problem? Check any one that describes your child's behavior.

Doesn't do what he/she is told Other:

Temper tantrums
Verbal abuse/argues with others
Hurts other people
Throws things
Bothers other people

Makes sounds or noises that bother people

Attention Deficits
Is overactive
Doesn't pay attention, but not overactive

Potty trained for urine, but has accidents

Complains of aches & pains
Headaches
Stomachache
Other

Tics
Pulls out own hair

Phobias
Separation anxiety

Self-stimulation
Hand flapping

☐ Body rocking
☐ Soiling accidents

During the day
At night

☐ Nail biting
☐ Thumb sucking
☐ Masturbation

☐ Doesn't want to interact with people
☐ Poor social skills

☐ Other _____
☐ Pica

☐ Depression
☐ Communication delays or deficits

☐ Breaks things

☐ Repeats what people say
☐ Speech doesn't make sense

☐ Self-Injury
☐ hitting
☐ Head-banging
☐ Arm/hand
☐ biting Eye
☐ gouging

☐ Insists that everything is always the same
☐ Head-
☐ Doesn't know how to play with others

ADAPTIVE BEHAVIOR

Check one that best describes your child's mental abilities.

☐ Normal Intelligence ☐ Mild ID ☐ Moderate ID ☐ Severe ID ☐ Profound Intellectual Disability (ID)

Check one that describes your child (you may check more than one).

☐ Walks on his/her own
☐ Uses words or signs to communicate
☐ Toilet trained
☐ Can imitate a model
☐ Follows Instruction
☐ Visually impaired
☐ Hearing impaired

What type of supervision does your child require? (Check one) Can be left unattended for brief periods of timeNeeds continuous monitoring, but can be accomplished in a group Requires 1:1 supervision

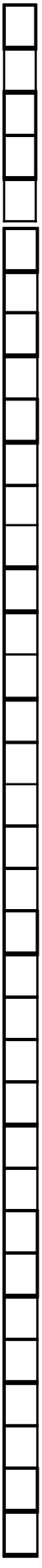
FOOD CHECKLIST

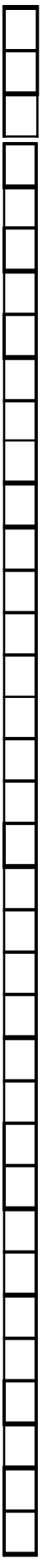
Child's Name: **Date:**

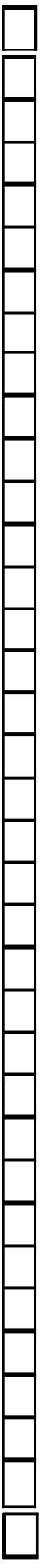
Instructions: Please mark the box that best describes your child's experience with the food listed below. Please note brand type/preferences, if applicable.

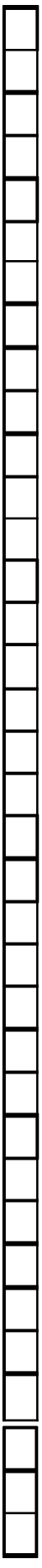
E= Eats this food consistently **T**= Has tried but refuses to eat
W= Would like my child to eat this food

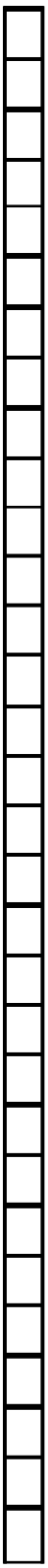
Food	**E**	**T**	**W**	**Food**	**E**	**T**	**W**







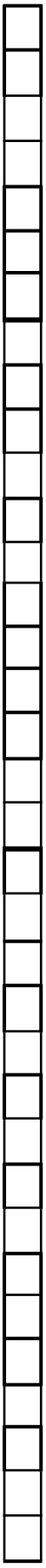


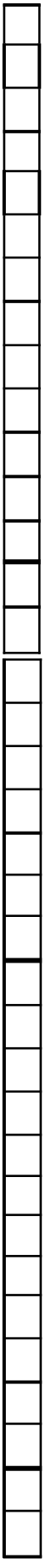


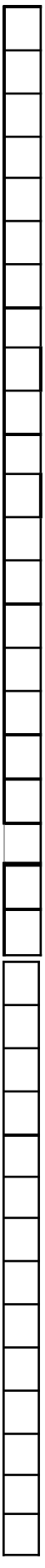
Bagel
Biscuits
Bread (Type:_____)
Brown & Wild Rice
Cereal (Type:_____)
Cream of Wheat (Type_____)
English Muffin
Eggs (Type:_____)Baked Potato
Fettuccini Alfredo
Grilled beef strips
Grilled chicken strips
Ham
Ham Sandwich
Ham & Cheese Sandwich
Fish sticks

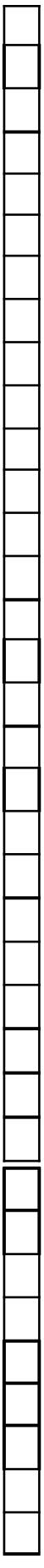
French Toast
French Fries
Grits
Hash Browns
Mashed Potatoes
Oatmeal (Flavor:_____)
Pancakes
Rice Cereal
Stuffing
Sweet Potato
Sweet Potato Fries
Tater Tots
Toaster Strudel
Waffles
White Rice
Almond
Bacon
Beanie Weanies
Bologna Sandwich
Cheese (Type:_____)
Cheeseburger
Chicken & Noodles
Chicken Breast
Chicken Broth
Chicken Noodle Soup
Chicken Nuggets
Hamburger
Hot dogs
Italian (Beef) Meatballs
Lasagna
Macaroni & Cheese
Nuggets (Type:_____)
PB&J Sandwich
Peanuts
Pistachios
Pork Sausage
Pudding
Rice
Spaghetti O's
Tuna
Turkey Breast
Turkey & Cheese Sandwich
Turkey Meatballs
Turkey Sausage
Uncrustable (Type:_____)
Veggie Burger
Walnuts
Yogurt (Flavor:_____)
Beef Stew
Beef Ravioli
Beef-a-Roni
Burrito (Type:_____)

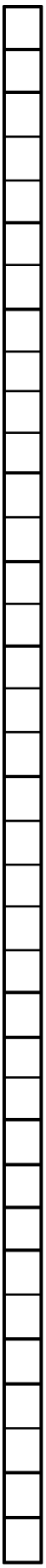
Food	E	T	W	Food	E	T	W







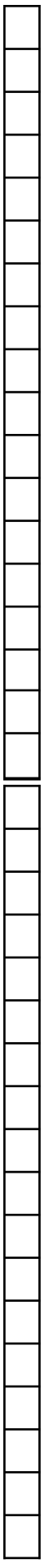


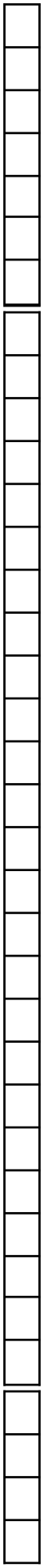


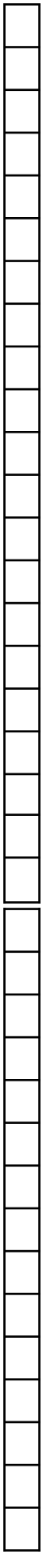
☐

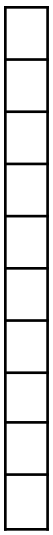
Chicken Pot Pie
Enchilada (Type:_____)
Macaroni & Beef
Pizza (Brand/Toppings)
Rice w/ Chicken & Vegetables
Soup (Type:_____)
Spaghetti & Meatballs
Apple
Apple Chips
Apple Sauce
Apricots
Banana
Banana Chips
Blackberries
Blueberries
Fruit Cocktail
Fruit Cup (Type:_____)
Mandarin Oranges
Mango
Melon
Peaches
Pears
Pineapple
Raisins
Raspberries
Strawberries
Asparagus
Baked Beans
Black Beans
Broccoli
Broccoli & Carrots
Broccoli & Cheese
Carrots
Cauliflower
Cauliflower & Cheese
Chickpeas
Corn
Collard Greens
Creamed Spinach
Green Beans
Breakfast Okra (Fried or Canned)
Peas
Peas & CarrotsChili Pickles
Spinach
Squash (Butternut/Summer)
Tomatoes
Vegetable Medley
Yams
Zucchini
Almond Butter
BBQ Sauce
Brown Sugar
Butter
Cashew Butter
Cream Cheese
Chocolate Syrup
Dressing (Type:_____)
Gravy (Type:_____)
Honey
Honey Mustard
Jam/Jelly (Flavor:_____)
Ketchup
Marinara Sauce
Mayonnaise
Mustard
Nutella (Hazelnut Spread)
Peanut Butter
Ranch
Salsa
Syrup (Type:_____)
White Sugar
Water
Milk (%:_____)
Cashew Milk (Type:_____)
Chocolate Milk
Soy Milk (Type:_____)
Almond Milk (Type:_____)
Orange Juice
Apple Juice
Cranberry Juice
Grape Juice
Carnation Instant

Instructions: Please indicate any additional foods not listed above that your child eats or you would like him/her to eat. Please provide type/brand preferences, if applicable.









Food E T W Food E T W

FOOD DIARY

Instructions:

Complete a food diary each day for 3 days, offering your child foods/drinks as you typically would.

- For each meal/snack, indicate when the meal/snack started and ended.
- List All the specific foods offered and the brand, when applicable.
- Indicate the amount of each food your child consumed.

EXAMPLE

Child's Name:

Meal time	Foods Offered (Type, Brand, & Quantity)	Amount Consumed
5:45 - 6:15 **AM**	1 cup Welch's Grape Juice	1cup
8:15 - 8:55 **AM**	4-ounce Yoplait Strawberry Yogurt	2ounces
	1/2 of Large Thomas Bagel	1/4 of bagel w/ cream cheese
	1 Tablespoon Philadelphia Cream Cheese	
	1/2 cup Skim Milk	1/2 cup
11:15 **AM** - 12:02 **PM**	Tyson Chicken Tender Strips	2 strips
	3 strips, cut into1/4ths	
	1/2 cup green beans	none
	1/2 cup Horizon Organics Chocolate Milk	1/2 cup
11:56 **AM** - 12:35 **PM**	6 oz container of Raisins	2 raisins
6:30 - 6:45 **PM**	3 cups Welch's Grape Juice	3 cups
6:54 - 7:45 **PM**	1/2 of Hillshire Farms Turkey	1 full slice of bread

	Sandwich with WonderBread (3 slices of turkey)	no turkey
	Small order McDonald's French Fries	entire order
	1 cup Aquafina Water	lcup
8:09 - 8:29 **PM**	Jif Peanut Butter and Celery 2 Tablespoons, 2 Sticks	entire portion

Sally
10/31/12

Date:

Child's **Name:**

Date:

	yp ,y	

Child's **Name:**

Date:

	yp ,y	

Child's **Name:**

Date:

	yp ,y	