Cheshire Fitness Zone and Pediatric Therapy

328 Main Street

Cheshire, CT

203-250-9663

(6 and under)

Patient:

Date of Birth

Date:

***Please take the time to complete this survey by providing as much detailed information as possible. It would also be helpful to share a video with your therapist during the initial evaluation of a typical feeding session at home.

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1) Does your child have an existing developmental or medical condition? If yes, please describe
   _____
   _____

2) Does your child have allergies? If yes, please describe
   _____
   _____

3) Has your child had a swallow study completed? If yes, where was it completed? Please describe results
   _____
   _____

4) Do you have concerns regarding your child's ability to swallow? If yes, please describe
   _____
   _____

5) Is there a history of or is your child currently tube fed? If yes, please describe
   _____
   _____

6) What routines are helpful for getting your child to eat meals? Please check all that apply
   rewards__ __preferred foods____ sticker chart__ __exercise before__ __specific utensils____ use of electronics including television, ipad, etc.____ use of a visual/picture schedule ____other____ (if other please describe)
   _____

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Updated March 2016

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Patient:

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For children birth to 1 year old

**Please check off all that apply

__ My child experienced difficulty latching on to the breast or bottle
__ I hear "gulpy" sounds when my child is drinking
__ My child turns his/her head often while being fed
__ My child cries often while being fed
__My child has coughing spells and or color changes while feeding
__ Excessive liquid spills from my child's mouth while eating/drinking
__My child falls asleep often during feeding
__Other (if other please describe) _____

For children 1 year and older

**Please check off all that apply

__ My child has coughing spells and or color changes while eating
__ Excessive liquid spills from my child's mouth while eating/drinking
__ My child frequently gags, chokes or coughs when eating
__ My child had difficulty transitioning from the bottle/breast to table food
__ My child refuses to eat, spits out or gags on food based on one or more of the following: temperature, food texture (crunchy or chewy foods), food color, smell
__ My child avoids touching certain foods/textures if yes, please describe_____
__ My child fidgets during mealtime
__ My child frequently wipes his/her mouth
__ My child is bothered by light touch to his/her face and or body
__ My child exhibits sensitivities to one or more of the following: itchy clothing, excessive movement, loud noises
__ My child exhibits one or more of the following oral motor sensitivities: mouthing objects, gags or vomits frequently, bites/chews objects frequently, grinds teeth
__ Other (if other please describe)_____