11030-101 Raven Ridge Road, Raleigh, NC 27614 Phone: 919-844-6611

Note: Please bring samples of foods/drinks that your child is currently eating in addition to foods that you would like your child to eat. Also bring cups, bottles, spoons, etc. that are currently used at home.

Oral Sensori-Motor Evaluation Intake Questionnaire

Child's Name _____ Date of Birth _____ Age_____ Gender M / F

Pediatrician/Group: _____

Name of person completing form_____ Relationship to child _____

Email Address _____

How did you hear about us? _____

Does your child have any diagnoses? _____

Primary Feeding Concerns _____

When did you first notice this concern?_____

What, if any, action has been taken to address the feeding concerns? _____

What are your goals for this evaluation? _____

Birth History:

Was your child born full term? Yes / No If no, how many weeks gestation? _____

Birth Weight _____ Birth Weight Percentile_____ Apgar Scores _____

Was your child in the NICU? Yes / No ____; If yes, why and for how long? _____

List any surgeries that were required. _____

Did your child require supplemental feedings? Yes / No If yes, what type and for how long? _____

Developmental History:

When did your child sleep through the night_____ roll over _____ sit independently _____

crawl _____ walk _____ say first words_____ toilet train _____?

Is/has your child required any other therapy? _____ If yes, explain. _____

_____

Do you have any other developmental concerns? Yes / No If yes, what? _____

Does your child attend day care or school? Yes / No If yes, where?_____

General Medical History:

Child's Current Weight _____ Weight Percentile _____ Height Percentile _____
Has your child's growth been steady? Yes / No
Has your child ever been hospitalized? _____; If yes, when and why? _____

_____

Current Medications:_____

Recurrent Medical Issues: Ear Infections / Upper Respiratory Infections / Colds Other_____

Is your child congested? Yes / No If yes, how often? Rarely / Frequently / Always

If yes, does the congestion worsen: when eating / when drinking ?

Does your child have any food allergies? Yes / No Do you suspect any food allergies? Yes / No

Is there any family history of food allergy? Yes / No If yes, who and to what? _____

Has your child even had allergy testing completed? Yes / No If yes, when and what were the results? _____

_____

Is your child allergic to latex? Yes / No

Gastrointestinal History:

Has your child been diagnosed with gastroesophageal reflux? Yes / No

If yes, what treatments have been utilized? _____

Have any diagnostic studies been completed? Yes / No If yes, when and what were the results? _____

_____

Is there a family history of gastroesophageal reflux/GI issues? Yes / No If yes, who?_____

Does your child currently spit up/vomit? Yes / No If yes, how often? _____

Are there whole pieces of food present in the vomit? Yes / No

Did your child spit up/vomit as an infant? Yes / No If yes, how often?_____

Does your child exhibit any of the following? (mark all that apply)

____crying/irritable during or after meals
____volume limiting
____grazing
____arching
____requiring distractions (book, TV) to eat
____requesting to eat but refusing
____coughing/gagging
____ limiting textures
____frequent hiccupping/burping
____frequent dry swallows outside of mealtimes

How many bowel movements does your child have each day? _____ Is food present in the stool? Yes / No

What is the consistency? Loose / Normal / Firm Do you have to stimulate bowel movements? Yes / No

Oral Motor History:

Does your child drool? Yes / No Is tooth brushing difficult? Yes / No

When did your child get his/her first tooth? _____

Does your child currently mouth objects? Yes / No Did he/she in the past? Yes / No

Does your child currently use a pacifier or suck his/her thumb? Yes / No Did he/she in the past? Yes / No

Feeding History:

What methods of feeding have been utilized? (Mark all that apply.)

____Breast ____Bottle ____Cup ____NG Tube

____G-Tube ____Puree ____Table Foods

What is the current form of your child's diet? _____

If nursing was discontinued, when and why? _____

Did/does your child drink formula? Yes / No Type of Formula: _____

Has your child been on any other formulas? Yes / No If yes, what and why was it changed? _____

_____ Did switching formulas cause any change? Yes / No

With liquids, does your child choke or cough? Yes / No If yes, how often? _____

With solids, does your child Choke / Cough / Gag ? If yes, how often? _____

Does your child indicate hunger? Yes / No Does your child indicate fullness? Yes / No

Has your child ever had a Modified Barium Swallow Study? Yes / No

If yes, when and what were the results?_____

	Age Introduced	Initial Response	Current Response
Smooth Puree			
Chunky Puree			
Crunchy Foods			
Soft Table Foods (pancakes, etc,)			
Firm Table Foods (apples, etc.)			

Does your family eat together? Yes / No Does your child eat from the family meal? Yes / No

How long does a meal take? ___ _____What percentage of your child's calories comes from liquids? _____

How many ounces does your child drink each day? Milk_____ Juice_____ Water_____

Are you concerned about your child's nutrition? Yes / No If yes, why? _____

Sensory Processing History:

Does your child like to swing? Yes / No Does your child play in/with: sand / grass / PlayDoh ?

Is your child sensitive to: fabrics / tags in clothing / loud sounds / messiness ?

Feeding Behaviors:

What strategies have you tried to manage your child's eating difficulties? (Mark all that apply.)

____Distraction during meals (books, games, TV)
____Withholding snacks or drinks
____Rewards/bribes
____Feeding child upon demand
____Coaxing
____Sneaking in new foods
____Forcing
____Allowing child to drink more fluids
____Short order cooking
____Punishment
____High calorie supplements
____Other_____

Does your child do any of the following during mealtime? (Mark all that apply.)

____Refusal to eat ____Tries to get out of seat ____Spits out food
____Falls asleep ____Cries/screams ____Gags/coughs
____Vomits ____Throws food/utensils ____Holds food in mouth
____Other _____

Where does your child eat best?_____ Where does your child sit to eat? _____

Does your child eat better for other people? Yes / No If yes, for whom?_____

Does your child feed him/herself? Yes / No Does your child use utensils to eat? Yes / No

Do you feel like your child is a picky eater? Yes / No What are you child's favorite foods?:_____

_____

Does your child appear stressed at mealtimes? Yes / No Are you stressed at mealtimes? Yes / No

Sample Diet: Please record a typical day's diet and intake volumes.

	Type & Amount of Food	Type and Amount of Liquid
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Evening Snack		