



# Pediatric Feeding Disorders Program

## Screening Form

### **Instructions:**

We need good information to give a good assessment. Please fill out this form and return it as soon as possible. We will call to **schedule** a team evaluation, **after we have received this form.** Please, send it to:

**Pediatric Feeding Disorders Program  
Attention: Cassie Winfield  
The Marcus Autism Center  
1920 Briarcliff Road  
Atlanta, GA 30329**

**Fax: 404.785-9440**

For proper evaluation, please provide copies of the following items prior to your visit:

1. Your child's most recent medical evaluation and medical records. We are interested in reviewing results from evaluations related to your concerns with feeding. You may wish to contact your child's pediatrician first to see if that office has copies of evaluation reports. Reports may be mailed or faxed to the location listed above.
2. Your child's typical daily mealtime schedule along with record of daily food intake (see Food Intake Record).

If you have any questions or need assistance please write or call Dr. David L. Jaquess, Ph.D., Director of the Pediatric Feeding Disorders Program, 404.785-9437. Thank you very much for you interest in the Pediatric Feeding Disorders Program.

**BIOGRAPHICAL**

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Caregivers' Name(s): \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Telephone: \_\_\_\_\_

Child's Legal Guardian: \_\_\_\_\_

How did you learn about our program? \_\_\_\_\_

Has your child been seen before at the Marcus Autism Center: \_\_\_\_\_ Yes \_\_\_\_\_ No

Name of person completing this form: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**FEEDING DIFFICULTY**

Please list feeding issues that are causing problems.

<u>Description of Behavior</u>	<u>When it started</u>
a. _____	_____
b. _____	_____
c. _____	_____

**WHO ELSE HAS TRIED TO HELP WITH THESE ISSUES?**

Please list your child's past and current therapies for feeding difficulties.

Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_ Phone: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ Therapy: \_\_\_\_\_

Did the therapy help? \_\_\_\_\_ If yes, how? \_\_\_\_\_  
=====

Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_ Phone: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ Therapy: \_\_\_\_\_

Did the therapy help? \_\_\_\_\_ If yes, how? \_\_\_\_\_  
=====

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Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_ Phone: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ Therapy: \_\_\_\_\_

Did the therapy help? \_\_\_\_\_ If yes, how? \_\_\_\_\_

**SCHOOL/DAY CARE**

School Name: \_\_\_\_\_ Teacher Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

List any special education services your child receives: \_\_\_\_\_

Has your child's school/day care addressed your child's feeding difficulties? \_\_\_\_\_

If yes, how? \_\_\_\_\_

Was this effective? \_\_\_\_\_ How? \_\_\_\_\_

**MEDICAL INFORMATION**

Medical problems or diagnoses at this time: \_\_\_\_\_

Was feeding interrupted at any time in your child's history? \_\_\_\_ Yes \_\_\_\_ No

For how long? \_\_\_\_\_ For what reason? \_\_\_\_\_

Hospitalizations (month/year & reason): \_\_\_\_\_

**Height: \_\_\_\_\_ Weight: \_\_\_\_\_ (We really need this; check with pediatrician if necessary.)**

Current medical problems: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

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Name of Gastroenterologist: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Please list any other physicians who are treating your child (attach separate sheet if needed):

Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Has your child had any recent procedures/surgeries?\_\_ Yes \_\_\_\_ No

If yes, what? \_\_\_\_\_ Dates: \_\_\_\_\_

Please check if your child has had the tests below.

- Swallow study (MBS / OPMS)      Date: \_\_\_\_\_ Result: \_\_\_\_\_
- Endoscopy      Date: \_\_\_\_\_ Result: \_\_\_\_\_
- Gastric Emptying      Date: \_\_\_\_\_ Result: \_\_\_\_\_
- pH probe      Date: \_\_\_\_\_ Result: \_\_\_\_\_
- Upper GI      Date: \_\_\_\_\_ Result: \_\_\_\_\_
- Allergy Testing
  - Skin Test      Date: \_\_\_\_\_ Result: \_\_\_\_\_
  - Blood Test      Date: \_\_\_\_\_ Result: \_\_\_\_\_

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

OXYGEN	Dates
tracheostomy	
nasal cannula	

FEEDING	Dates	Amount	Formula	% of daily intake	How? Continuous/ Bolus
G-tube					
NG-tube					
Other					

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**Bowel Habits:**

Frequency of Bowel Movements: \_\_\_\_\_ times per (circle one): DAY WEEK

Consistency: HARD SOFT LOOSE WATERY

Please list your child's current medications.

Medication	Dose	Prescribing Doctor

**CURRENT FEEDING PRACTICES**

Current Skills (Check all that apply.)

a. How is child positioned for feeding?	<input type="checkbox"/> Regular chair @ table <input type="checkbox"/> Booster seat <input type="checkbox"/> High chair <input type="checkbox"/> Reclined chair <input type="checkbox"/> Adaptive chair, type: _____ Other:
b. _____ Drinks from bottle	Special adaptation, type _____ Does your child hold the bottle? _____ Type of nipple used: _____
c. _____ Fed by parents?	How?
d. _____ Feeds self with fingers?	Large pieces _____ Small _____
e. _____ Feeds self with spoon?	Special adaptation, type _____ Independent __ Needs help __
f. _____ Feeds self with fork?	Independent __ Needs help __
g. _____ Uses knife?	Spreads __ Cuts __
h. _____ Drinks from cup/glass?	Special adaptation type _____
i. _____ Drinks from straw?	
j. _____ Pours own drink?	
k. _____ Prepares own snack?	
l. _____ Has child <i>ever</i> self-fed?	

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Where does your child currently eat?  adult's lap  booster seat  infant seat  table/chair  
 high chair  other (please specify) \_\_\_\_\_

My child eats:  alone or  with the family?

At what age were solids introduced? \_\_\_\_\_

Was a nipple/pacifier used during neonatal period?  Yes  No

During infancy, was child fed by bottle \_\_\_\_\_, breast \_\_\_\_\_, combination \_\_\_\_\_

Food consistency: please check all that are currently applicable:

	<u>does eat</u>	<u>can eat</u>	<u>never eats</u>	<u>can't eat</u>	<u>has not tried</u>
liquids/soups	_____	_____	_____	_____	_____
strained baby food	_____	_____	_____	_____	_____
junior baby	_____	_____	_____	_____	_____
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 have behavior problems during meal times?  Yes  No

Check all behaviors, which are **problematic** during mealtimes:

<input type="checkbox"/>	Throws food	<input type="checkbox"/>	messy eater
<input type="checkbox"/>	Spits food	<input type="checkbox"/>	takes food from others
<input type="checkbox"/>	Cries, screams	<input type="checkbox"/>	refuse food
<input type="checkbox"/>	Leaves the table before finished	<input type="checkbox"/>	overeats
<input type="checkbox"/>	Only eats certain foods	<input type="checkbox"/>	Other: _____

What do you do when your child has behavior problems during a meal? \_\_\_\_\_

List any foods consistently accepted:

- fruits \_\_\_\_\_
- meats \_\_\_\_\_
- breads, cereals \_\_\_\_\_
- vegetables \_\_\_\_\_
- dairy products \_\_\_\_\_
- sweets \_\_\_\_\_

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Describe any special diet (Kosher, gluten-free, etc.) \_\_\_\_\_

Why do you think your child refuses foods/liquids? \_\_\_\_\_

Meal Pattern

Please indicate your child's typical mealtime schedule and sample meals. Give approximate amounts.

	<u>Sample/Typical Meal</u>	<u>Approximate Mealtime</u>
Morning -	_____	_____
Afternoon -	_____	_____
Evening -	_____	_____
Snacks -	_____	_____

Describe the sequence in which food is offered to your child (e.g., liquids always first, etc.):

\_\_\_\_\_

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

Your child's appetite is best described as (circle one):

poor                  fair                  good                  excellent                  eats too much

How long does it take for your child to complete a meal? (circle one)

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

How does your child indicate hunger? \_\_\_\_\_

What do you do when your child refuses to eat/drink \_\_\_\_\_

**ORAL MOTOR STATUS**

Check all behaviors, which are a **problem** during mealtimes:

<input type="checkbox"/>	Drooling	<input type="checkbox"/>	Vomiting/Rumination
<input type="checkbox"/>	Continuous sucking; poor sucking	<input type="checkbox"/>	Teeth Grinding
<input type="checkbox"/>	Biting (independently biting off pieces of food)	<input type="checkbox"/>	Coughing
<input type="checkbox"/>	Tongue control (tongue thrust, poor mobility)	<input type="checkbox"/>	Gagging
<input type="checkbox"/>	Swallowing	<input type="checkbox"/>	Profuse perspiration (diaphoresis)
<input type="checkbox"/>	Lip control (keeping his/her mouth closed)	<input type="checkbox"/>	Aspiration
<input type="checkbox"/>	Chewing (for children over 12 months)	Other:	
<input type="checkbox"/>	Hypersensitivity to food textures, temperature, spoon		

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**ADAPTIVE BEHAVIOR**

Circle each of the following that applies:

- a. Can walk (ambulatory)
- b. Can Use words or signs to communicate
- c. Can imitate a model
- d. Can follow instructions
- e. Has trouble seeing (visually impaired)
- f. Has trouble seeing (hearing impaired)
- g. Is toilet-trained

Estimated mental functioning (circle one):

Above Average      Normal intelligence      Mild Mental Delay      Moderate Mental Delay      Severe or Profound Mental Delay

**OTHER BEHAVIORS**

Does your child appear to enjoy social interaction?      \_\_\_ Yes      \_\_\_ No

Does your child require special supervision (for example, to avoid self-injury)?      \_\_\_ Yes      \_\_\_ No

If yes, explain: \_\_\_\_\_

Does your child have problems going to sleep at night?      \_\_\_ Yes      \_\_\_ No

If yes, explain: \_\_\_\_\_

Is your child toilet trained?      \_\_\_ Yes      \_\_\_ No

Are there any concerns with toileting?      \_\_\_ Yes      \_\_\_ No

If yes, explain: \_\_\_\_\_

Record any other problem behaviors (NOT RELATED TO FEEDING) that your child displays; describe it specifically. Include any damage resulting form the problem behavior either to your child or others. Please list in order of concern to yourself or other caretakers, with the behavior of most concern listed first.

	<u>Behavior</u>	<u>Description</u>
a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____

How bad is the problem behavior that causes the most concern (circle one):

Moderate                      Severe                      Life-threatening

Other information related to severity, risk, etc.: \_\_\_\_\_

\_\_\_\_\_

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How often does your child have this problem behavior not related to feeding (circle one)?

- a. Less than one episode per week (list frequency)
- b. 1 to 3 times per week
- c. Occurs about once daily
- d. Occurs several times per day
- e. Occurs every hour while awake

How long has your child been having the problem behavior(s) not related to feeding (circle one)?

- a. Within past 6 months
- b. More than 6 months but less than 1 year
- c. More than 1 year but less than 3 years
- d. More than 3 years but less than 5 years
- e. More than 5 years but less than 10 years

When is the problem behavior(s) not related to feeding likely to occur (circle all that apply)?

- a. When child is left alone or unattended
- b. When lots of people are around
- c. When told to do something
- d. Mealtimes, dressing, or bathing (circle)
- e. Other: \_\_\_\_\_

**Family Information:**

Who lives with this child ? (relationship & age) \_\_\_\_\_

Mother / caregiver occupation: \_\_\_\_\_

Father / caregiver occupation: \_\_\_\_\_

My child's health insurance provider(s) is/are: \_\_\_\_\_

What else would you like for us to know?

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Thank you for taking the time to fill out this information!

## THREE DAY FOOD RECORD

Instructions: Record all food/fluid consumed during the next three days. Please be as specific as possible to ensure accuracy of the analysis. Record the amount eaten in either volume (tbsp, cup) or weight (g, oz) measurements. Include brand names and methods of preparation when appropriate

Note: If an altered texture is being consumed i.e., pureed table food or wet ground, the yield of the "mixture" should be recorded as well as the amount consumed.

For example:

<b>Date:</b>	<b>Food Item:</b>	<b>Yield (total serving):</b>	<b>Amount Eaten:</b>
4/13/00	pureed chicken nuggets (4 nuggets, 1/2 c whole milk)	1 cup	1/3 cup
	carrots, canned		3 tbs.
	red grapes		25 ea.
	Kraft shells and cheese		1/2 cup
	Homemade Mango Shake (1 c mango, 1 1/2 c Wh. Milk)	2 cup	3/4 cup
	Tube-feeding: pediasure		480 cc/ml

<b>Date:</b>	<b>Food Item:</b>	<b>Yield:</b>	<b>Amount Eaten:</b>

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<b>Date:</b>	<b>Food Item:</b>	<b>Yield:</b>	<b>Amount Eaten:</b>

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<b>Date:</b>	<b>Food Item:</b>	<b>Yield:</b>	<b>Amount Eaten:</b>