_____

Child's Name

FEEDING & ORAL MOTOR/OT (fill out only if there are feeding concerns)

Child's Current Weight _____ Growth Chart Percentile_____

Was your child breast fed? Yes ____ No ____ Comments

_____

Was your child bottle fed? Yes ____ No ____ Comments

_____

Drinks from? bottle breast sippie cup straw open cup

Utensils used? fork spoon finger fed caregiver assist

History Of:

	Yes	No
Reflux		
Vomiting		
Constipation		
Diarrhea		
Slow Gastric Emptying		
Failure to Thrive		

Difficulty with Feeding/Oral Motor Skills:

	Yes	No
Over-stuffing mouth with food		
Gags/vomits during feedings		
Frequently drools		
Messy eater		
Strong food preferences		
Picky eater		
Avoids face washing		
Avoids tooth brushing		
Not chewing food		
Spillage of food/drinks from their mouth		
Avoids being messy		
Pocketing		
Grazes		
Throws food		
Difficulties using cup and/or straw		
Mouths objects/fingers		

Special Diet _____

Shows signs of hunger YES NO

Food texture preferences (if so, please describe; crunchy, smooth, warm, cold, etc.) _____

Feeding environment High Chair___ Table___ Walks Around____ Other_____

How long does your child sit for a meal? _____

Food likes (please list)_____

_____

Food dislikes (please list) _____

_____