All in 1 S.P.O.T. with TheraTalk, SLP, PT, OT, PLLC.
150-50 14th Road
Whitestone, NY 11357
Tel: (718) 767-0091/0071
Fax: (718) 767-0086

www.spotwiththeratalk.com

SPOT's Feeding Hierarchy: Evaluation Intake Form

Date Form Completed: _____
Person Completing Form: _____

Client's Name: _____

Date of Birth:_____Age:_____Parents/ Caregivers: _____

Address: _____

Preferred Phone:_____Home:_____Cell: _____

Referred by: _____
(NAME)

_____
(ADDRESS)

Reason(s) for Referral: _____
_____

When did you first notice the problem(s)? Please describe: _____
_____
_____

Does your child have a medical diagnosis(es)? Please describe: _____
_____

Previous/Ongoing - Evaluations/Treatments None □
(Please give date(s) and results of tests and dates of treatments)

Audiological _____

Feeding and Swallowing Evaluation _____

Speech and Language Evaluation _____

Occupational Therapy _____

Physical Therapy _____

Special Education _____

Current Educational or Program Placement _____

Medical History

Were there medical problems during the pregnancy? □ Yes □ No

If yes, please describe: _____

Did your child have nutritional problem(s)? □ Yes □ No

Failure to thrive? □ Yes □ No
Unplanning weight loss? □ Yes □
No Dehydration? □ Yes □ No
Was tube feeding needed? □ Yes Please specify: □ Nasogastric □ Gastrostomy
□ No
If yes, why?_____For how long? _____
Does tube feeding continue? □ Yes □ No
Allergies: □ Yes □ No If yes, please list: _____
_____

Current Height _____ Current Weight _____ Date of Measurements _____

Has your child experienced problems with nipple feeding? □ Yes □ No

Does your child have a history of drooling? □ Yes □No
Does drooling continue? □ Yes □ No
Please describe: _____

_____

Has your child had a history of respiratory health issues? □ Yes □No
Asthma □ Yes □No
Lower respiratory infections □ Yes □ No Number per year: _____
Pulmonary disorder □ Yes □ No
Other _____

Has your child experienced problems with the ear, *eyes,* nose, or throat? □ Yes □ No

Vision yes no
Hearing □ Yes □ No
Ear Infections □ Yes □ No
Tonsils and Adenoids □ Yes □ No
Other _____

Has your child experienced gastrointestinal problems? □ Yes □ No

Spitting □ Yes □ No
Vomiting □ Yes □ No
Constipation □ Yes □ No
Infections □ Yes □ No
Obstruction □ Yes □ No
Other _____

Has your child had a neurological exam? □ Yes □ No
If yes, please describe: _____
_____

Has your child had cardiac problem(s)? □ Yes □ No
If yes, please describe: _____
_____

Has your child had psychological problems? □ Yes □ No
If yes, please describe: _____
_____

Has your child had dental problem(s)? □ Yes □ No
If yes, please describe: _____
_____

Current Routine Medications: _____
_____
_____

Developmental History
Please list the ages that the child first met these developmental milestones:

Crawling _____ Sitting without support _____
Walking _____ Running _____
Use of gestures _____ Use of words _____
Use of sentences _____ Speaking clearly_____

Does your child use special equipment for mobility? If yes, please describe:

_____
_____
_____
_____

Does your child use special equipment for communication? If yes, please describe:

_____
_____
_____
_____

Feeding and Swallowing Development

Milestones	**Age Milestone Was Acquired (please indicate in months or years)**
Controlling saliva	
Nipple feeding	
Eating from spoon	
Accepting teething biscuit, bites	
Accepting cup	
Accepting crisp pieces	
Accepting variety of food tastes and textures	
Drinking from straw	
Chewing soft table food easily	
Chewing cut-up meat, firm fruit/veg	
Unrestricted table foods	
Accepting medications preparations	
Increasing bolus size, viscosity, and rate of eating	
Accepted pureed foods	
Accepted mashed texture	
Chewing foods well	

Self-feeding milestones	**Age Milestone Was Acquired (please indicate in months or years)**
Held own bottle	
Fed self with fingers	
Fed self with spoon	
Fed self with fork	
Drank from open cup	
Held own cup and drank from straw	

Current Management and Eating Habits

What is your child's current feeding/eating schedule (meals and snacks)?:_____
_____
_____
_____
(For combined oral and tube feeding, fill in both below)
For tube feeding (Schedule & amount of time to finish): _____
_____
For oral feeding (Schedule & amount of time to finish for meals and snacks): _____
_____
Please describe:
Seating during eating: _____
Utensils used during eating: _____

Food preparations that child eats

Solids: □ Jarred □ Table food □ Puree □ Mashed/Ground □ Chewable
Examples: _____
Liquids: □ Nipple bottle □ Open cup
□ Sippy cup □ Straw
Other special equipment: □ Yes □ No If yes, please describe: _____
_____
Special feeding strategies (Routine/Techniques): □ Yes □ No If yes, please describe:
_____

Does your child sit/stay in chair until finished eating? □ Yes □ No

What foods are in your child's current diet?
Grains □ Yes □ No Examples: _____
Fruit □ Yes □ No Examples: _____
Vegetables □ Yes □ No Examples: _____
Meat □ Yes □ No Examples: _____
Dairy □ Yes □ No Examples: _____

Does your child:

Enjoy eating?	□ Yes	□ No
Resist eating solids?	□ Yes	□ No
Resist liquids?	□ Yes	□ No
Cry during eating?	□ Yes	□ No

Other. Please describe: _____
_____

Please describe the mealtime behaviors when your child eats a meal: _____

_____

Do you use special feeding strategies to control behaviors? □ Yes □ No
If yes, please describe_____

What foods/textures does your child prefer? _____

Does your child have disruptive mealtime behaviors? □ Yes □ No
If yes, please describe: _____

Does your child gag, cough, or choke on food or saliva? □ Yes □ No
If yes, please describe: _____

Description of Feeding Difficulties (List your child's mealtime behaviors and age of onset)_____

_____

_____

_____

_____

_____

Current # Accepted Foods: _____
Current # Accepted Liquid(s): _____

Has your child been seen by a pediatrician, gastroenterologist or any other physician regarding feeding difficulties?
If yes what were the results of the evaluation?_____

_____

_____

_____

Has your child had any of the following tests?

	Date	**Results**
□ Swallow study (MBS)	_____	_____
□ Endoscopy	_____	_____
□ PH probe	_____	_____
□ Upper GI	_____	_____
□ Allergy testing		
Skin test:	_____	_____
Blood test:	_____	_____

□ Other _____

_____

Please list any medications that your child is currently taking :

1. _____
2. _____
3. _____
4. _____

Current feeding skills

1. Seating (how is your child seated for meals):
   - Regular Chair at the table
   - Booster chair/ high chair
   - Reclined chair
   - Adaptive chair
   - Other: _____

2. Drinking:
   Does your child drink for a bottle, sippy cup, or regular cup?_____
   Can your child hold the bottle or cup independently?_____
   Does your child use a straw to drink?_____

3. Feeding:
   Do you feed your child?_____
   Does your child self feed with his/her fingers?_____
   Does your child self feed with a spoon?_____
   Does your child self feed with a fork?_____
   Does your child use a knife? _____

Texture Preferences

- □ Liquids/Soups
- □ Strained baby food
- □ Junior baby food
- □ Creamy/Smooth foods (yogurt)
- □ Blended/Pureed table food
- □ Mashed table food with lumps
- □ Chopped
- □ Crispy (chips,crackers,toast)
- □ Chewy foods (meats)
- □ Crunchy foods (carrots, celery)
- □ Regular table foods

Taste Preferences

- □ Salty
- □ Sweet
- □ Spicy
- □ Tart
- □ Flavored
- □ Bland

Temperature Preferences

- □ Hot
- □ Warm
- □ Cold
- □ Cool

List any foods consistently accepted:

Fruits	

Meats	
Breads, cereals, chips	
Vegetables	
Dairy products	
Sweets	

Appetite
Best time of the day to eat _____

Overall description of appetite
□ Poor
□ Fair
□ Good
□ Varies from day to day

Mealtime lengths

Less than 10 minutes 10-20 mins 20-30 mins 30-60 mins. Overs 60 mins

Is your child following any special diets? (Kosher,glutein free etc.)

Description of typical meals:

Morning	
Afternoon	
Evening	
Snacks	

Does your child eat little meals and snacks throughout the day?_____
_____

How does your child indicate hunger?_____
_____

Please list your child's favorite foods/liquids:

1._____
2._____
3._____
4._____
5._____

Please list your child's least-favorite foods/liquids:
1._____
2._____
3._____
4._____
5._____

What goal foods would you like to see your child independently accept?
1._____
2._____
3._____

Are there times when you child eats better?_____
_____

Mealtime Behaviors
Does your child display any behavioral problems during meals? _____
_____
_____

Check all that apply?
□ Throws food
□ Spits food
□ Gags
□ Cry/Scream
□ Leaves the table
□ Only eats certain foods
□ Messy eater
□ Refuse food
□ Covers eyes, ears, nose, mouth
□ Stuffs mouth
□ Other:

What is your response to your child's behavior problems during a meal?_____
_____
_____
_____

Oral Motor Skills:
Check all behaviors are problematic during meals:
□ Drooling
□ Poor sucking

□ Biting
□ Tongue control (tongue thrust)
□ Swallowing
□ Lip control
□ Chewing
□ Hypersensitivity to food textures, temperature, utensils
□ Vomitting
□ Gagging
□ Tooth grinding
□ Coughing
□ Other:

2 Day Meal Record

Please write down all meals and snacks eaten by your child over a 2 day period. Be as specific as possible.

Day 1

Food item & description (Texture, temperature, brand etc.)	Amount eaten

Day 2

Food item & description (Texture, temperature, brand etc.)	Amount eaten

To what extent are the following scenarios problematic for your child? **Circle the appropriate response**	**0 = No problem**				**4 = Severe problem**
1. My child's swallowing problem has caused him/her to lose weight or to gain insufficient weight.	0	1	2	3	4
2. My child's swallowing problem interferes with his/her ability to go out for meals with the family.	0	1	2	3	4
3. Swallowing liquids takes extra effort for my child.	0	1	2	3	4
4. Swallowing solids takes extra effort for my child.	0	1	2	3	4
5. Swallowing pills takes extra effort for my child.	0	1	2	3	4
6. Swallowing appears to be painful for my child.	0	1	2	3	4
7. For my child, the pleasure of eating is affected by his/her swallowing.	0	1	2	3	4
8. When my child swallows, food seems to stick in his/her throat.	0	1	2	3	4
9. My child coughs when he/she eats.	0	1	2	3	4
10. It is stressful for my child to swallow.	0	1	2	3	4
Total EAT-10 modified:					

Belafsky, P.C., Mouadeb, D.A., Rees, C.J., Pryor, J.C., Postma, G.N., Allen, J.A., and Leonard, R.J. (2008). Validity and reliability of the Eating Assessment Tool (EAT-10). *Annals of Otology, Rhinology,*
& Laryngology, 117 (12): 919-924

FOR EVALUATOR TO COMPLETE:

Pt Name:_____ Date:_____

Feeding modality_____ Date of Birth _____

Diagnosis_____

Oral Pharyngeal Sensorimotor Examination of Swallowing-Pediatric (OPSES-P)

WNL – within normal limits
ABNL – abnormal
L – Left,
R – Right
N – No,
Y – Yes
Scoring: 0=Normal; 1=Mild; 2=Moderate; 3=Severe

CN	Oral Postural Control	WNL	ABNL	Score	Comments
VII	Lips approximated				
V	Mandible elevated				
XII	Tongue w/I dental arch				

CN	Saliva Control	WNL	ABNL	Score	Comments
IX, X	Swallows > 1 per 3 min				
IX, X	Clear breath sounds				
V, XII	Saliva contained (absent drooling)				
V, IX, X, XII	Voluntary saliva swallow				

	Face				
CN		**WNL**	**ABNL**	**Score**	**Comments**
VII	Facial expression				
	symmetry				
	Tics / Grimaces				
	Tremor				
	Facial Droop:				**If yes, side:**
VII	Smile (retraction of lips)				
VII	Kiss				
V	Jaw on resistance				
	open				
	close				
V	Sensation of face (w/ aesthesiometer)				**Test infant reflexes.**
	Oral Cavity				

XII	Symmetry of tongue on protrusion				
	Symmetry In mouth				
XII	Tongue at rest	[redacted]			

	Fasciculations				
	Atrophy				
XII	spontaneous tongue motion:				
	Up				
	Down				
	Left				
	Right				
	Active protrusion				
X	Velum at rest	**WNL**	**ABNL**	**Score**	
	asymmetry				
	tremor				
IX, X	Elevation of soft palate during /a/				
IX, X, V, XII VII	Gag reflex	**L**	**R**	**L**	**R**
	Mandible/lip range				
	Tongue protrusion/grooving				
	Palatal elevation				
	Pharyngeal contraction				
	Voice and Speech				
X	Voice quality				
	Wet hoarse	**N**	**Y**		
	Dry hoarse	**N**	**Y**		
	Breathy	**N**	**Y**		
	Nasal	**N**	**Y**		
	Other (aphonia)	**N**	**Y**		
X	Audible respiration	**N**	**Y**		
X	Voluntary cough				
X	Pitch				
X	Volume				
X	Maximum phonation time (3x) Age norms	**WNL**	**ABNL**	**Score**	
		1			
		2			
		3			
V & VII	Diadochokinetic rates	**WNL**	**ABNL**	**Score**	
	papapa: 5-7 reps/sec				
	tatata: 5-7 reps/sec				
	kakaka: 4-6 reps/sec				
	buttercup: 4-7 reps/sec				
	Head and Shoulders				
XI	Steady head against resistance (both sides)				
XI	Steady shoulders on resistance				
XI	Head-neck, shoulder stability				

Anatomy	WNL	ABNL	Comment
Facies			
Lips and cheeks			
mandible			
Maxilla			
Dentition and gums			
Tongue			
Palate and uvula			
Larynx/trachea			
Thorax			
Tracheostomy			

TOTAL SCORE: _____

Additional Comments: _____