

**Pediatric Feeding Disorders Program**

**Instructions:**

Please complete this online screening form and 3-day food record BEFORE your child's evaluation. Also, please mail us:

1. Your child's most recent medical evaluation and medical records.
2. Records of therapy (previous and current) for your child's feeding difficulties.
3. A current videotape sample of a "typical" mealtime with your child (if available).

You may send this information by e-mail to [mnieman@unmc.edu](mailto:mnieman@unmc.edu)

If you have any questions or need assistance please call Melissa Nieman at 402.559.7039 or Fax 402.559.55950 or email [mnieman@unmc.edu](mailto:mnieman@unmc.edu). Thank you very much for your interest in the Pediatric Feeding Disorders Program.

Sincerely,  
Cathleen Piazza, Ph.D.  
Director, Pediatric Feeding Disorders Program  
Professor, Department of Pediatrics  
Munroe-Meyer Institute  
University of Nebraska Medical Center

**BIOGRAPHICAL**

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Caregiver/Legal Guardian

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

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

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

Telephone: \_\_\_\_\_ (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c)

Has your child been seen before at the Munroe-Meyer Institute:  Yes  No

**Please check one of the boxes by double clicking on the box and selecting "checked" under default value**

**REFERRAL INFORMATION**

Who referred you to the Pediatric Feeding Disorders Program at the Munroe-Meyer Institute?

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

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

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

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**CURRENT MEDICAL PROVIDERS**

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

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

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

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

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

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

**INSURANCE**

Who is responsible for this account? \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Is the patient covered by additional insurance?  Yes  No

Subscriber's name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

**SCHOOL/DAY CARE**

Name of School: \_\_\_\_\_ Teacher: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

In your opinion, would the school/day care be willing to follow a treatment for your child's feeding problems?  
 Yes  No

**PRIOR PROFESSIONAL CONTACTS**

Please list all past and current therapies your child has received by completing each of the boxes below.

Service	Start/End Date (month/year)	How often?	Length of each therapy session	Did therapy focus on feeding?	Effect of therapy for feeding problem	Therapist information (name, address, telephone)
Occupational Therapy  <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1x/month <input type="checkbox"/> 2x/month <input type="checkbox"/> 1x/week <input type="checkbox"/> 2x/week <input type="checkbox"/> 3x/week <input type="checkbox"/> _____	<input type="checkbox"/> 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> 1 hr <input type="checkbox"/> 1.5 hr <input type="checkbox"/> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Worse  <input type="checkbox"/> No change  <input type="checkbox"/> Improved	
Physical Therapy  <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1x/month <input type="checkbox"/> 2x/month <input type="checkbox"/> 1x/week <input type="checkbox"/> 2x/week <input type="checkbox"/> 3x/week <input type="checkbox"/> _____	<input type="checkbox"/> 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> 1 hr <input type="checkbox"/> 1.5 hr <input type="checkbox"/> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Worse  <input type="checkbox"/> No change  <input type="checkbox"/> Improved	
Speech  <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1x/month <input type="checkbox"/> 2x/month <input type="checkbox"/> 1x/week <input type="checkbox"/> 2x/week <input type="checkbox"/> 3x/week <input type="checkbox"/> _____	<input type="checkbox"/> 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> 1 hr <input type="checkbox"/> 1.5 hr <input type="checkbox"/> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Worse  <input type="checkbox"/> No change  <input type="checkbox"/> Improved	
Early Intervention  <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1x/month <input type="checkbox"/> 2x/month <input type="checkbox"/> 1x/week <input type="checkbox"/> 2x/week <input type="checkbox"/> 3x/week <input type="checkbox"/> _____	<input type="checkbox"/> 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> 1 hr <input type="checkbox"/> 1.5 hr <input type="checkbox"/> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Worse  <input type="checkbox"/> No change  <input type="checkbox"/> Improved	
Nutrition  <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1x/month <input type="checkbox"/> 2x/month <input type="checkbox"/> 1x/week <input type="checkbox"/> 2x/week <input type="checkbox"/> 3x/week <input type="checkbox"/> _____	<input type="checkbox"/> 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> 1 hr <input type="checkbox"/> 1.5 hr <input type="checkbox"/> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Worse  <input type="checkbox"/> No change  <input type="checkbox"/> Improved	
Others: (please list)		<input type="checkbox"/> 1x/month <input type="checkbox"/> 2x/month <input type="checkbox"/> 1x/week <input type="checkbox"/> 2x/week <input type="checkbox"/> 3x/week <input type="checkbox"/> _____	<input type="checkbox"/> 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> 1 hr <input type="checkbox"/> 1.5 hr <input type="checkbox"/> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Worse  <input type="checkbox"/> No change  <input type="checkbox"/> Improved	

## MEDICAL INFORMATION

### Personal/Social History

Child lives with:  mom  dad  both parents  other caregiver: \_\_\_\_\_

Siblings/ages \_\_\_\_\_

Grades in school/performance \_\_\_\_\_

# of days missed (school &/or daycare) \_\_\_\_\_

Anyone smoke at home \_\_\_\_\_

Pets at home \_\_\_\_\_

Activities/interests \_\_\_\_\_

Recent stress or change \_\_\_\_\_

### Birth History

How many weeks pregnant were you when your child was born? \_\_\_\_\_

Was your child born by vaginal delivery or c-section? \_\_\_\_\_

What was your child's birth weight/length? \_\_\_\_\_ lbs \_\_\_\_\_ cms \_\_\_\_\_

Was your child's stool passage within the first 24 hours? \_\_\_\_\_

Were there any problems at birth? \_\_\_\_\_

Were there any problems during pregnancy? \_\_\_\_\_

**Family History** (e.g., colitis, inflammatory bowel disease, ulcerative colitis, Crohn's, colon polyps, colon cancer, celiac disease, irritable bowel syndrome, allergies, asthma, thyroid, liver, diabetes, mental health issues, or other medical conditions)

Please list \_\_\_\_\_

### Gastrointestinal Symptoms

Trouble swallowing  Yes  No \_\_\_\_\_

Nausea or vomiting  Yes  No \_\_\_\_\_

Vomiting blood or bile  Yes  No \_\_\_\_\_

Appetite change  Yes  No \_\_\_\_\_

Heartburn  Yes  No \_\_\_\_\_

**Abdominal Pain:** (if your child does not have abdominal pain, write N/A for the first question and go on to the next section)

How long has your child had abdominal pain? \_\_\_\_\_

How often does it happen? \_\_\_\_\_

At what time of the day does it happen? \_\_\_\_\_

How long does the pain last? \_\_\_\_\_

Any pain at night when sleeping? \_\_\_\_\_

Is the pain better or worse with food? \_\_\_\_\_

What type of food affects the pain? \_\_\_\_\_

Does the pain improve with a bowel movement? \_\_\_\_\_

What have you tried to help with the pain? \_\_\_\_\_

How much school is missed because of pain? \_\_\_\_\_

### Bowel History

Is your child toilet trained? \_\_\_\_\_

Does your child wet the bed? \_\_\_\_\_

How often does your child have stools? \_\_\_\_\_

Are the stools:  Hard formed,  soft formed,  pudding, or  watery

Do the stools vary in consistency? \_\_\_\_\_

Does your child take laxatives to stool? \_\_\_\_\_

Does your child have accidents in his or her underwear? \_\_\_\_\_

Does your child exhibit any stool withholding behavior? \_\_\_\_\_

Any blood in the stools? \_\_\_\_\_ Any black/tarry stools \_\_\_\_\_

Any mucous in the stools? \_\_\_\_\_

**Other GI**

Liver disease \_\_\_\_\_

Gallbladder disease \_\_\_\_\_

Jaundice \_\_\_\_\_

Irritable bowel disease \_\_\_\_\_

Inflammatory bowel disease \_\_\_\_\_

**Medical History**

Current Diagnoses \_\_\_\_\_

Previous illnesses \_\_\_\_\_

Past surgeries/hospitalizations \_\_\_\_\_

Current medications and dosages: \_\_\_\_\_

Allergies: Medications/Environmental/Seasonal \_\_\_\_\_

Allergies: Foods \_\_\_\_\_

Food intolerance? (e.g., lactose intolerance) \_\_\_\_\_

Previous illnesses \_\_\_\_\_

Past surgeries/hospitalizations \_\_\_\_\_

Are immunizations up-to-date? \_\_\_\_\_

If not up-to-date, what is delinquent? \_\_\_\_\_

Any developmental concerns? \_\_\_\_\_

**Review of Systems**

*General*

Weight loss  Yes  No

If yes, how much? \_\_\_\_\_ lb; over what period of time did this weight change occur? \_\_\_\_\_

Weight gain  Yes  No

If yes, how much? \_\_\_\_\_ lbs; over what period of time did this weight change occur? \_\_\_\_\_

Unexplained fevers  Yes  No

Unusual fatigue  Yes  No

Poor appetite  Yes  No

Poor sleeping  Yes  No

*Skin*

Eczema  Yes  No

Rashes  Yes  No

*Ear Nose and Throat*

Frequent ear infections  Yes  No

Sores in mouth  Yes  No

Sinus problems  Yes  No

*Respiratory*

Pneumonia  Yes  No

Asthma/wheezing  Yes  No

Chronic cough  Yes  No

*Cardiovascular*

Heart murmur  Yes  No

Heart disease  Yes  No

*Genitourinary*

Blood in urine  Yes  No

Pain with urination  Yes  No

Muscle/Skeletal

Joint pain/stiffness  Yes  No

Back pain  Yes  No

Hematology/Lymphatic

Enlarged lymph nodes  Yes  No

Excessive bruising  Yes  No

Bleeding of gums  Yes  No

Nose bleeds  Yes  No

History of anemia  Yes  No

Neurologic

Seizures  Yes  No

Frequent headaches  Yes  No

Migraine headaches  Yes  No

Unusual/excessive fussiness/irritability  Yes  No

Endocrine

Diabetes  Yes  No

Thyroid  Yes  No

Growth problems  Yes  No

Psychosocial

Anxiety  Yes  No

Depression  Yes  No

School avoidance  Yes  No

Recent stresses  Yes  No

Abuse (physical, emotional, sexual)  Yes  No

Insomnia/trouble sleeping  Yes  No

Drug/alcohol use  Yes  No

**FEEDING HISTORY**

Was there a time when you did not or were not able to give your child food or liquid by mouth?

Yes  No

How long? \_\_\_\_\_ How old was your child at the time? \_\_\_\_\_

Why? \_\_\_\_\_

Has this problem resolved?  yes  no if yes, when did it resolve? \_\_\_\_\_

**Medical Tests**

Please check if your child has had the tests below. Write down the date (as best as you can remember) when the test was done.

TEST	DATE
<input type="checkbox"/> MBS/OPMS/VFSS (swallow study)	
<input type="checkbox"/> Endoscopy	
<input type="checkbox"/> Gastric Emptying	
<input type="checkbox"/> pH probe	
<input type="checkbox"/> Upper GI	

Tell us if your child had or has any of the following:

	HAD	HAS NOW
Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>
Nasal cannula	<input type="checkbox"/>	<input type="checkbox"/>
OG-tube	<input type="checkbox"/>	<input type="checkbox"/>
NG-tube	<input type="checkbox"/>	<input type="checkbox"/>
G-tube	<input type="checkbox"/>	<input type="checkbox"/>
J-tube	<input type="checkbox"/>	<input type="checkbox"/>

**Tube Feeding**

Formula type: \_\_\_\_\_

Tube feeding schedule:

Time	Amount	Method (Pump, Gravity, Bolus)	Rate

If your child consumes oral feedings in addition to his/her tube feedings, please complete the “Meal Pattern” section below.

Does your child have a special diet?  Yes  No

If yes, what is it? \_\_\_\_\_

Your child’s appetite is best described as (check one):

- poor
- fair
- good
- excellent
- eats too much

Does your child tell you when he or she is hungry?  Yes  No

How?  tells me what he/she wants  points at food/cabinet/refrigerator  goes and gets the food/can/package  cries  takes me to the cabinet/refrigerator  \_\_\_\_\_

**Meal Pattern**

Give us an example of when, where, what, and how much your child eats at each meal.

Meal	Time	Location	Food and Approximate Amount
Breakfast			
AM Snack			
Lunch			
PM Snack			
Dinner			
other Snack			

Height: \_\_\_\_cm\_\_ Weight: \_\_\_\_lbs\_\_ List the date these measurements were taken: \_\_\_\_\_

Where were these measurements taken?  pediatrician’s office;  other clinic/medical facility;  home  
(PLEASE SEND A GROWTH CHART FROM YOUR PEDIATRICIAN’S OFFICE WITH GROWTH MEASURES FROM BIRTH, IF POSSIBLE).

**Chronology**

As an infant, my child was:

- bottle fed,
- breast fed,
- both,
- neither.

When bottle or breast fed, my child:

- drank very little,
- drank about half of what he/she was supposed to,
- drank most of what he/she was supposed to.

Tell us how old your child was (write the age in the column labeled “child’s age”) when you first started feeding each of the foods listed under “type of food” and tell us how your child reacted (“refused” or “accepted”) to each type of food. For example, if you started cereal at 6 months, write 6 months under “child’s age”, next to the line with the word “cereal” in it, then check whether your child “refused” or “accepted” the cereal.

CHILD'S AGE	TYPE OF FOOD	CHECK ONE	
	Cereals	<input type="checkbox"/> REFUSED	<input type="checkbox"/> ACCEPTED
	Baby food	<input type="checkbox"/> REFUSED	<input type="checkbox"/> ACCEPTED
	Mashed food	<input type="checkbox"/> REFUSED	<input type="checkbox"/> ACCEPTED
	Table food	<input type="checkbox"/> REFUSED	<input type="checkbox"/> ACCEPTED

**CURRENT FEEDING BEHAVIOR**

Right now, my child eats in a

regular chair  booster seat  high chair  my lap  \_\_\_\_\_.

During meals, my child  eats with the rest of the family  does not eat with the rest of the family.

How long does it take for your child to eat a meal? (check one)

- less than 10 minutes
- 10-20 minutes
- 20-30 minutes
- 30-40minutes
- 40-60 minutes
- more than 60 minutes

**Current Feeding Skills**

Check the one(s) that describe your child.

- |  |  |
|--|--|
| <input type="checkbox"/> Drinks from bottle      | <input type="checkbox"/> Drinks from cup/glass |
| <input type="checkbox"/> Fed by caregivers       | <input type="checkbox"/> Drinks from straw     |
| <input type="checkbox"/> Feeds self with fingers | <input type="checkbox"/> Pours own drink       |
| <input type="checkbox"/> Feeds self with spoon   | <input type="checkbox"/> Prepares own snack    |
| <input type="checkbox"/> Feeds self with fork    |  |
| <input type="checkbox"/> Uses knife              |  |

Tell us about what your child does and does not eat RIGHT NOW. You may check more than one box for each food.

DOES EAT means that your child will eat the food most of the time when you serve it.

CAN EAT means that your child has the skill or ability to eat the food (even if he or she does not eat it).

NEVER EATS means that your child never or rarely will eat the food when you serve it.

CAN'T EAT means that your child does not have the skill or ability to eat the food even if he or she is willing to eat it.

HAS NOT TRIED means you have never given the food to your child.

	does eat	can eat	never eats	can't eat	has not tried
liquids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
baby food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
creamy foods (ice cream, yogurt)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
blenderized table food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mashed table food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
chopped table food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
regular table food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
crisp foods (crackers, toast)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
chewy foods (meat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
crunchy foods (carrots, celery)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Write down the foods that your child will USUALLY eat when you serve them.

fruits \_\_\_\_\_

meats \_\_\_\_\_

starches \_\_\_\_\_

vegetables \_\_\_\_\_

liquids \_\_\_\_\_

junk food \_\_\_\_\_

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

**ORAL MOTOR BEHAVIOR**

My child had or has the following problems (you may check more than one):

<b>PROBLEM</b>	<b>HAD</b>	<b>HAS NOW</b>
Drooling	<input type="checkbox"/>	<input type="checkbox"/>
Poor suck	<input type="checkbox"/>	<input type="checkbox"/>
Can't bite off pieces of food	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with tongue control (tongue thrust, poor mobility)	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with lip control (can't keep his/her mouth closed)	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty chewing (for children over 12 months)	<input type="checkbox"/>	<input type="checkbox"/>
Over sensitivity to food textures, temperature, spoon	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting/Rumination	<input type="checkbox"/>	<input type="checkbox"/>
Teeth grinding	<input type="checkbox"/>	<input type="checkbox"/>
Coughing with certain foods/drinks	<input type="checkbox"/>	<input type="checkbox"/>
Gagging with certain foods/drinks	<input type="checkbox"/>	<input type="checkbox"/>
Grunting	<input type="checkbox"/>	<input type="checkbox"/>
Profuse perspiration (diaphoresis)	<input type="checkbox"/>	<input type="checkbox"/>
Aspiration	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

**OTHER BEHAVIORS**

**SLEEP**

Check any that describe your child:

- |  |  |
|--|--|
| <input type="checkbox"/> Has difficulties going to sleep at night    | <input type="checkbox"/> Has difficulties staying asleep   |
| <input type="checkbox"/> Tantrums when put to bed                    | <input type="checkbox"/> Has difficulties staying in bed   |
| <input type="checkbox"/> Has other behavior problems when put to bed | <input type="checkbox"/> Wants to sleep in caregiver's bed |
| <input type="checkbox"/> Has difficulties going to sleep during naps |  |

My child goes to bed at \_\_\_\_\_ pm.

My child wakes up at \_\_\_\_\_ am.

My child takes a nap from \_\_\_\_\_ to \_\_\_\_\_ and \_\_\_\_\_ to \_\_\_\_\_.

## **OTHER BEHAVIOR PROBLEMS**

Does your child have any other behaviors that you think are a problem? Check any one that describes your child's behavior.

- |   |   |
|---|---|
| <input type="checkbox"/> Doesn't do what he/she is told             | <input type="checkbox"/> Other _____                                    |
| <input type="checkbox"/> Temper tantrums                            | Complains of aches and pains  |
| <input type="checkbox"/> Verbal abuse/argues with others            | <input type="checkbox"/> Headaches                                      |
| <input type="checkbox"/> Hurts other people                         | <input type="checkbox"/> Stomachache                                    |
| <input type="checkbox"/> Throws things                              | <input type="checkbox"/> Other  |
| <input type="checkbox"/> Bothers other people                       | <input type="checkbox"/> Tics   |
| <input type="checkbox"/> Makes sounds or noises that bother people  | <input type="checkbox"/> Pulls out own hair                             |
| Attentional Deficits  | <input type="checkbox"/> Phobias  |
| <input type="checkbox"/> is overactive                              | <input type="checkbox"/> Academic underachievement                      |
| <input type="checkbox"/> doesn't pay attention, but not over active | <input type="checkbox"/> Skips school                                   |
| Self-stimulation  | <input type="checkbox"/> Separation Anxiety                             |
| <input type="checkbox"/> Body rocking                               | Potty trained for urine, but has accidents                              |
| <input type="checkbox"/> Hand flapping                              | <input type="checkbox"/> during the day                                 |
| <input type="checkbox"/> Nail biting                                | <input type="checkbox"/> at night                                       |
| <input type="checkbox"/> Thumb sucking                              | <input type="checkbox"/> Soiling accidents                              |
| <input type="checkbox"/> Masturbation                               | Accident Proneness  |
| <input type="checkbox"/> Other _____                                | <input type="checkbox"/> Burns  |
| <input type="checkbox"/> Pica                                       | <input type="checkbox"/> Poisons  |
| <input type="checkbox"/> Breaks things                              | <input type="checkbox"/> Falls  |
| <input type="checkbox"/> Steals                                     | <input type="checkbox"/> Doesn't want to interact with people           |
| <input type="checkbox"/> Lies                                       | <input type="checkbox"/> Poor social skills                             |
| <input type="checkbox"/> Sets fires                                 | <input type="checkbox"/> Depression                                     |
| <input type="checkbox"/> Runs away                                  | <input type="checkbox"/> Communication delays or deficits               |
| Self-Injury   | <input type="checkbox"/> Repeats what people say                        |
| <input type="checkbox"/> Head-hitting                               | <input type="checkbox"/> Speech doesn't make sense                      |
| <input type="checkbox"/> Head-banging                               | <input type="checkbox"/> Insists that everything is always the same way |
| <input type="checkbox"/> Arm/hand biting                            | <input type="checkbox"/> Doesn't know how to play with others           |
| <input type="checkbox"/> Eye gouging                                |   |

## **ADAPTIVE BEHAVIOR**

Check the one that best describes your child's mental abilities.

- Normal intelligence     Mild MR     Moderate MR     Severe MR     Profound MR

Check the ones that describe your child (you may check more than one).

- |   |  |
|---|--|
| <input type="checkbox"/> Walks on his/her own               | <input type="checkbox"/> Follows instruction |
| <input type="checkbox"/> Uses words or signs to communicate | <input type="checkbox"/> Visually impaired   |
| <input type="checkbox"/> Toilet trained                     | <input type="checkbox"/> Hearing impaired    |
| <input type="checkbox"/> Can imitate a model                |  |

What type of supervision does your child require (circle one)?

- Can be left unattended for brief periods  
 Needs continuous monitoring, but can be accomplished in a group  
 Requires 1:1 supervision

### 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 (e.g., pureed table food or wet ground), the yield of the "mixture" should be recorded as well as the amount consumed.

For example:

Date:	Food Item:	Yield:	Amount Eaten:
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
	Tubefeeding: pediasure		480 cc/ml

Date:	Food Item:	Yield:	Amount Eaten:

Date:	Food Item:	Yield:	Amount Eaten: