


FEEDING ASSESSMENT


Screen



Name of person conducting the screen _____

		Always	Some-times	Occas-ionally	Never
1	Does your child have any problems with eating and drinking?				
2	Does your child eat the same food as other children the same age?				
3	Does your child cough or choke while eating or drinking?				
4	Is your child growing and putting on weight like other children?				
5	Does your child vomit during/after a meal? How often?				
6	Does your child have any breathing difficulties? asthma / wheeze / prolonged cough / chesty cold pneumonia				
7	Does your child have constipation?				
8	Does your child dribble/drool?				

ACTION: Referral for further assessment? **Yes / No**

<h1 style="margin: 0;">FEEDING ASSESSMENT</h1> <h2 style="margin: 0;">History</h2>	
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Child's age:	<input style="width: 100%;" type="text"/>	Height/length:	<input style="width: 100%;" type="text"/>
Sex:	<input style="width: 100%; text-align: center;" type="text" value="M / F"/>	Upper arm circumference:	<input style="width: 100%;" type="text"/>
Weight:	<input style="width: 100%;" type="text"/>	Weight Z-score:	<input style="width: 100%;" type="text"/>

Name of doctor: _____

Name of therapist: _____

QUESTIONS:

1. What problems is your child having with feeding? Don't ask specific questions, ask: 'any other problems'?

1.	4.
2.	5.
3.	6.

2. DIET: What does your child eat in a normal day?

Time	What	Consistency		Utensil
<i>Example</i> 7.00 am	<i>Suji</i>	1 Thin liquid √2 Thick liquid 3 Puree 4 Soft solid /chewy	A Mixed √B Smooth	<i>Feeder bottle</i>
10.00 am	<i>Roti mixed with milk</i>	1 Thin liquid 2 Thick liquid 3 Puree √4 Soft solid/chewy	√ A Mixed B Smooth	<i>Caegiver's hand</i>
		1 Thin liquid 2 Thick liquid 3 Puree 4 Soft solid / chewy	A Mixed B Smooth	
		1 Thin liquid 2 Thick liquid 3 Puree 4 Soft solid / chewy	A Mixed B Smooth	
		1 Thin liquid 2 Thick liquid 3 Puree 4 Soft solid / chewy	A Mixed B Smooth	
		1 Thin liquid 2 Thick liquid 3 Puree 4 Soft solid / chewy	A Mixed B Smooth	
		1 Thin liquid 2 Thick liquid 3 Puree 4 Soft solid / chewy	A Mixed B Smooth	
		1 Thin liquid 2 Thick liquid 3 Puree 4 Soft solid / chewy	A Mixed B Smooth	
		1 Thin liquid 2 Thick liquid 3 Puree 4 Soft solid / chewy	A Mixed B Smooth	
		1 Thin liquid 2 Thick liquid 3 Puree 4 Soft solid / chewy	A Mixed B Smooth	

Date _____ Child's name: _____ Carer's name _____

TOTAL number of meals per day

3. FLUID INTAKE:

How much does your child drink in a day? (*Show big glass*) _____ ml / (approximation)

How do you give it?

- | | |
|--|---|
| <p>1. Feeder bottle <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/></p> <p>2. Tall metal glass <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/></p> <p>4. Teaspoon <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/></p> <p>7. Small plastic cup <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/></p> <p>9. Other: _____</p> | <p>6. Trainer cup with lid <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/></p> <p>3. Short metal glass <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/></p> <p>5. Large spoon <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/></p> <p>8. Tall glass <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/></p> |
|--|---|

4. DURING feeding:

	Always	Some-times	Occas- ionally	Never
Is your child particular about what it eats – eg. only eats one type of food, one colour of food, at certain times only?				
Do you have to force feed your child?				
Do you feed your child at fixed times only? (or also when it is hungry)				
Do you finish the meal because the food is finished? (or because the child wants to stop)				
Do you feel sad				
Do you feel frustrated				
Do you feel angry				
Do you have any other feelings when you feed your child? If so, what? :				

<h2 style="margin: 0;">FEEDING ASSESSMENT</h2> <h3 style="margin: 0;">Observation checklist</h3>
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POSITION

Body	Head
Lying down	Very extended
Breast feeding position	Slightly extended
Sitting slouched	Neither extended nor flexed
Sitting well supported	Slightly flexed
Other:	Very flexed

CHILD'S FEEDING BEHAVIORS

EATING		v
Oral behaviours	1. Aversive behaviour to oral-tactile input	
	2. Absence of response to oral input	
	3. Excessive drooling / oral spillage	
	4. Limited lip closure	
	5. Tongue pumping	
	6. Tongue thrust	
	7. Limited lateralisation of tongue / jaw	
	8. Bite reflex / hypersensitivity	
	9. Spitting out	
	10. Pocketing	
	11. Other eg. signs of struggle/grimace	

Feeding pattern: Suckling > Munching > Chewing

Date _____ Child's name: _____ Carer's name _____

Pharyngeal / oesophageal signs		Occas	Freq
	1. Wet sounds in throat		
	2. Throat-clearing		
	3. Coughing		
	4. Choking		
	5. Gagging		
	6. Becoming breathless/noisy breathing		
	7. Face changing colour / tears in eyes		
	8. Becoming distressed during / after swallow		
	9. Nasal regurgitation		
	10. Oral regurgitation		

DRINKING		√
Oral behaviours	1. Aversive behaviour to oral-tactile input	
	2. Absence of response to oral input	
	3. Excessive drooling / oral spillage	
	4. Ltd use of lips / lip closure	
	5. Ltd jaw opening / stabilisation	
	6. Tongue pumping or munching action	
	7. Tongue thrust	
	8. Bite reflex	
	9. Spitting out	
	10. Other	

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Social interaction during mealtime

Normal Abnormal.....

Specific food refusal.....

Sensory observations

Hypersensitive..... Hyposensitive.....

FEEDING DIAGNOSIS:

Normal

Developmental delay

Dysphagia: **Oral stage difficulties**

Oro-pharyngeal stage difficulties

Oesophageal

Selective eater

Behavioural