CENTER FOR PEDIATRIC BEHAVIORAL HEALTH

PEDIATRIC FEEDING DISORDERS PROGRAM INTAKE FORM

Please complete and submit this intake form to the Center for Pediatric Behavioral Health:

E-mail: info@centerforpbh.com
Fax: (910) 660-8199
Mail: Center for Pediatric Behavioral Health
Pediatric Feeding Disorders Program Intake
720 St. James Drive
Wilmington, NC 28403

In addition to the screening form, please send or request the following information from your child's other providers (if applicable). We must receive the following information **before** we are able to schedule your child's initial evaluation:

	Referral from your primary care physician and/or specialist
	Records from your child's last three doctor appointments and/or specialist appointments
	Graphical depictions of your child's growth chart from birth
	Test results (e.g., swallow study, endoscopy, oral-motor evaluation)
	Records from previous or current therapy for your child's feeding (e.g., OT, speech)
	Copies of your child's IEP or school-based interventions
	Video sample of a "typical" mealtime with your child from a recent meal

The initial evaluation will consist of an interview portion and a mealtime observation. Please bring the following materials to the initial evaluation:

	Three of your child's preferred food and drink items
	Three of your child's nonpreferred or novel food and drink items
	Any utensils, toys, or items your child uses during a meal

If you have any questions or need assistance, please call (910) 660-8200 or email info@centerforpbh.com.

BIOGRAPHICAL

Child's Name: _____ Date of Birth: _____

Caregiver(s)/Legal Guardian(s):

Name(s): _____ Relation to Client: _____
Address: _____
City, State, Zip: _____
Telephone: _____ (Home) _____ (Work)
_____ (Cell) _____ (Other)
E-mail: _____
Other individuals living in the home: _____

Name(s): _____ Relation to Client: _____
Address: _____
City, State, Zip: _____
Telephone: _____ (Home) _____ (Work)
_____ (Cell) _____ (Other)
E-mail: _____
Other individuals living in the home: _____

CURRENT MEDICAL PROVIDERS

Name of Primary Care Physician: _____
Affiliation: _____
Address: _____
City, State, Zip: _____
Telephone: _____ Fax: _____

Name of Gastroenterologist: _____
Affiliation: _____
Address: _____
City, State, Zip: _____
Telephone: _____ Fax: _____

Name of Other Provider (Allergist, Pulmonologist, etc.): _____
Affiliation: _____
Address: _____
City, State, Zip: _____
Telephone: _____ Fax: _____

Name of Other Provider (Allergist, Pulmonologist, etc.): _____
Affiliation: _____
Address: _____
City, State, Zip: _____
Telephone: _____ Fax: _____

CURRENT PHARMACY AND SUPPLIES INFORMATION

Pharmacy: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

Durable Medical Equipment (DME) Provider: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

What supplies are you currently receiving from your DME? Please include size information.

_____

Do you have back up supplies (e.g., gastrostomy tube) or emergency kit (e.g., foley, KY, syringe)? _____

What supplies are not covered by your DME but your child is currently using? _____

_____

PRIOR PROFESSIONAL CONTACTS

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

Service Type	Start and End Dates	How Often?	How Long?	Focus on Feeding?	Effect on Feeding Problem	Therapist Information
Occupational Therapy ☐ Yes ☐ No	Start: ___ / ___ End: ___ / ___	☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	Name: Address: Telephone: Fax:
Physical Therapy ☐ Yes ☐ No	Start: ___ / ___ End: ___ / ___	☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	Name: Address: Telephone: Fax:
Speech ☐ Yes ☐ No	Start: ___ / ___ End: ___ / ___	☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	Name: Address: Telephone: Fax:
Early Intervention ☐ Yes ☐ No	Start: ___ / ___ End: ___ / ___	☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	Name: Address: Telephone: Fax:

Nutrition ☐ Yes ☐ No	Start: ___ / ___ End: ___ / ___	☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	Name: Address: Telephone: Fax:
GI ☐ Yes ☐ No	Start: ___ / ___ End: ___ / ___	☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	Name: Address: Telephone: Fax:
Others:	Start: ___ / ___ End: ___ / ___	☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	Name: Address: Telephone: Fax:
Others:	Start: ___ / ___ End: ___ / ___	☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____	☐ Yes ☐ No	☐ Worse ☐ No change ☐ Improved	Name: Address: Telephone: Fax:

MEDICAL INFORMATION

Family History: Check if any family members have a history of the following, list relation (e.g., maternal grandmother) to child, and list additional information about type of condition.

	Condition	Relation		Condition	Relation
☐	Autoimmune (e.g., lupus, rheumatoid arthritis)		☐	Gallbladder disease	
☐	Asthma		☐	Gastroesophageal reflux disease (e.g., acid reflux, heartburn)	
☐	Celiac disease		☐	Inflammatory bowel disease (e.g., ulcerative colitis, Crohn's)	
☐	Colon cancer		☐	Irritable bowel syndrome	
☐	Developmental or intellectual delay or disability		☐	Kidney disease	
☐	Diabetes		☐	Liver disease	
☐	Eczema		☐	Mental health difficulties (e.g., anxiety, depression, bipolar)	
☐	Environmental allergies		☐	Thyroid disease	
☐	Food allergies		☐	Other: _____	
☐	Food intolerances		☐	Other: _____	

If yes, please provide additional information (e.g., type of condition, age diagnosed): _____
_____
_____

Birth History

When did you begin receiving prenatal care? _____
Were there any problems during pregnancy? _____
How many weeks pregnant were you when your child was born? _____
Was your child born by vaginal delivery or C-section? _____
If C-section, why? _____
Where there any complications during delivery? _____
What was your child's birth weight/length? _____ kg _____cm
Was your child's bowel movement within the first 24 hours? _____
Were there any problems at birth? _____
Did your child require oxygen at delivery? _____

Gastrointestinal Symptoms: Check if your child experiences any of the following

	Condition	Comment		Condition	Comment
☐	Appetite change		☐	Liver disease	
☐	Choking and gagging		☐	Nausea	
☐	Gallbladder disease		☐	Sandifer syndrome	
☐	Gastroesophageal disease (e.g., acid reflux, heartburn)		☐	Trouble swallowing	
☐	Inflammatory bowel disease		☐	Vomiting (e.g., blood, coffee grounds, bright green bile, undigested food)	
☐	Irritable bowel syndrome		☐	Other:	
☐	Jaundice		☐	Other:	

If yes, please provide additional information (e.g., type of condition, date diagnosed): _____
_____
_____

Abdominal Pain: Write N/A and move to the next section if your child does not have abdominal pain.

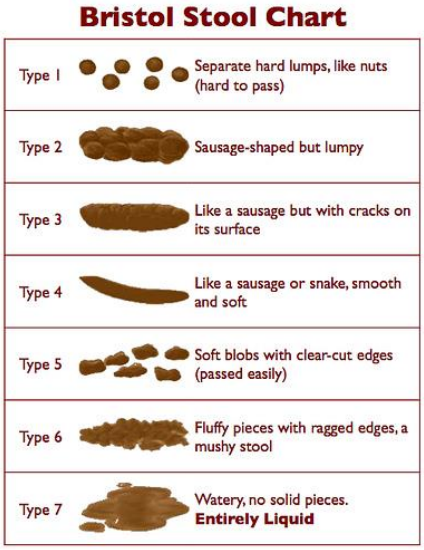
How long as your child had abdominal pain? _____
How often does it happen? _____
At what time of day does it happen? _____
How long does the pain last? _____

Does your child wake up at night with abdominal pain? _____
Does eating or drinking make the pain better or worse? _____
What type of food or drink affects the pain? _____
Does the pain improve with a bowel movement? _____
How much school is missed because of the pain? _____

Where is the location of the pain? ☐ Around the belly button ☐ Above belly button ☐ Right upper quadrant
☐ Right lower quadrant ☐ Left upper quadrant ☐ Left lower quadrant

Bowel History

At what age did your child toilet train? Urine: _____ Bowel Movements: _____
Does your child have accidents during the day? Urine: _____ Bowel Movements: _____
Does your child have accidents at night? Urine: _____ Bowel Movements: _____
How often does your child have a bowel movement? _____
Does your child complain of pain when he or she has a bowel movement? _____
Does your child exhibit any stool-withholding behavior? _____



Using the Bristol Stool Log, what type(s) best describe your child's stools? _____
Do the stools vary in consistency? _____
What do they vary to and from? _____
Does your child's stool float? _____
Any blood in the stools? _____
Any black/tarry stools? _____
Any mucous in the stools? _____

If your child takes medication (i.e., laxatives, softeners) for his or her stools, what doses and how often? _____
_____
If your child takes over-the-counter supplements (i.e., herbal), what amount and how often? _____
_____

Medical History

Current Medical Diagnoses: _____
_____
What treatment provider gave the diagnosis? When? _____
Current Psychological or Developmental Diagnoses: _____
_____
What treatment provider gave the diagnosis? When? _____
Previous Illnesses and Treatment Dates: _____
_____
Who was the treatment provider? Location of treatment? _____
Past Surgeries/Hospitalizations and Dates: _____
_____
Who was the treatment provider? Location of treatment? _____

Current Medications:

Name:	Dosage:	Frequency:	Method of Delivery: (e.g., oral, pill, tube)	Notes:

Allergies/Intolerances:

	Type(s):	Adverse Reaction:	Provider:	Date of Reaction:	Notes:
Drug					
Environmental					
Seasonal					
Food					
Food					
Other:					

Review of Systems

General

Weight loss ☐ Yes ☐ No

If yes, how much? _____ lbs. Over what period of time did weight loss occur? _____

Weight gain ☐ Yes ☐ No

If yes, how much? _____ lbs. Over what period of time did weight gain 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 & Throat

Frequent ear infections	☐ Yes	☐ No
Sores in mouth	☐ Yes	☐ No
Sinus problems	☐ 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

Endocrine

Diabetes	☐ Yes	☐ No
Thyroid	☐ Yes	☐ No
Growth problems	☐ Yes	☐ No

Respiratory

Pneumonia	☐ Yes	☐ No
Asthma/wheezing	☐ Yes	☐ No
Chronic cough	☐ Yes	☐ No
Nighttime coughing	☐ Yes	☐ No
Reactive Airway	☐ Yes	☐ No
Snoring	☐ Yes	☐ No

Hematology/Lymphatic

Enlarged lymph nodes	☐ Yes	☐ No
Excessive bruising	☐ Yes	☐ No
Bleeding of gums	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
History of amnesia	☐ Yes	☐ No

Neurologic

Seizures	☐ Yes	☐ No
Frequent headaches	☐ Yes	☐ No
Migraine headaches	☐ Yes	☐ No
Excessive fussiness	☐ Yes	☐ No
Unusual irritability	☐ Yes	☐ No

Any other medical concerns? _____

_____

_____

_____

Any developmental concerns? _____

_____

_____

_____

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 since been resolved? ☐ Yes ☐ No
If yes, when was it resolved? _____

Medical Tests: Please check if your child has had the following tests below

TEST	DATE(S)	RESULTS	TEST LOCATION	PROVIDER
☐ MBSS/OPMS/VFSS (Swallow study)				
☐ Endoscopy				
☐ Gastric Emptying				
☐ pH probe				
☐ Upper GI Series				
☐ Lower GI Series				
☐ Other: _____				
☐ Other: _____				
☐ Other: _____				

Tell us if your child has any of the following:

	HAD	HAS NOW	DATE(S) PLACED	DATE(S) REMOVED	LOCATION AND PROVIDER
Tracheostomy	☐	☐			
Nasal cannula	☐	☐			
OG-tube	☐	☐			
NG-tube	☐	☐			
G-tube	☐	☐			
J-tube	☐	☐			

Tube Feeding

Formula Name: _____ Type: _____
Cal/mL: _____ Other (e.g., fiber, iron) _____
Formula Recipe: _____

Tube Feeding Schedule:

Time	Amount	Method (Pump, Gravity, Bolus)	Rate

Does your child receive any water flushes? _____
If yes, how frequently and what amount? _____

Oral Feeding

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

Does your child have a special diet? ☐ Yes ☐ No

If yes, what is it? _____

If your child has a home blend/puree or a specific food mixture he or she eats, what is the recipe? _____

_____

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

☐ Poor ☐ Good ☐ Eats too much

☐ Fair ☐ Excellent

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

☐ Tells me what he/she wants ☐ Cries

☐ Points at food/cabinet/refrigerator ☐ Takes me to the cabinet/refrigerator

☐ Goes and gets food/can/package ☐ Other: _____

Meal Pattern: Give us an example of when, where, what, & how much your child eats at each meal

Meal	Time	Location	Food & Approximate Amount
Example: Lunch	12:00 PM	Living room on sofa	½ Peanut butter and grape jelly on whole wheat bread
Breakfast			
AM Snack			
Lunch			
PM Snack			
Dinner			
Other Snack			

Chronology

As an infant, my child was

☐ Bottle fed ☐ Both

☐ Breast fed ☐ Neither

When bottle or breast fed, my child

☐ Drank very little ☐ Drank most of what he/she was supposed to

☐ Drank half of what he/she was supposed to

Milestones: Tell us your child's age when you first started feeding the foods listed under "type of food." Tell us how your child reacted ("refused" or "accepted") to each type of food.

CHILD'S AGE	TYPE OF FOOD	CHECK ONE	
	Cereals	☐ Accepted	☐ Rejected
	Baby food	☐ Accepted	☐ Rejected
	Mashed food	☐ Accepted	☐ Rejected
	Table food	☐ Accepted	☐ Rejected

Did your child every reject a previously accepted food or accept an initially rejected food? _____

_____

Height: _____ cm Weight: _____ kg. List the date when these measurements were taken: _____

Where were these measurements taken? ☐ Home ☐ Pediatrician's Office ☐ Other clinic/medical facility

CURRENT FEEDING BEHAVIOR

Right now, my child eats in a
☐ Regular chair ☐ Booster seat ☐ High chair ☐ My lap ☐ Other: _____

Does your child eat with the rest of the family? ☐ Yes ☐ No
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

How long does it take for your child to eat a meal?
☐ Less than 10 minutes
☐ 10-20 minutes
☐ 20-30 minutes
☐ 30-40 minutes
☐ 40-60 minutes
☐ More than 60 minutes

Current Feeding Skills: Check the one(s) that describe your child.
☐ Drinks from bottle
☐ Fed by caregiver
☐ Feeds self with fingers
☐ Feeds self with spoon
☐ Feeds self with fork
☐ Uses knife
☐ Drinks from cup/glass
☐ Drinks from a straw
☐ Pours own drink
☐ Prepares own snack

What percentage of meals does your child feed himself or herself?
☐ 0%
☐ 25%
☐ 50%
☐ 75%
☐ 100%

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/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/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	☐	☐	☐	☐	☐
Baby food	☐	☐	☐	☐	☐
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)	☐	☐	☐	☐	☐

List the foods and liquids your child consistently eats and drinks:

Fruits	
Grains	
Proteins	
Vegetables	
Junk foods	
Liquids	

Current Oral-motor Behavior: Check all that apply

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

ADAPTIVE BEHAVIOR

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

☐ Normal Intelligence ☐ Mild ID ☐ Moderate ID ☐ Severe ID ☐ Profound Intellectual Disability (ID)

Check one that describes your child (you may check more than one).

☐ Walks on his/her own
☐ Uses words or signs to communicate
☐ Toilet trained
☐ Can imitate a model
☐ Follows Instruction
☐ Visually impaired
☐ Hearing impaired

What type of supervision does your child require?

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

Sleep: Check any that describe your child.

☐ Has difficulty going to sleep at nigh
☐ Tantrums when put to bed
☐ Has other behavior problems when put to bed
☐ Has difficulties going to sleep during naps
☐ Has difficulties staying asleep
☐ Has difficulties staying in bed
☐ Wants to sleep in caregiver's bed

My child goes to bed at _____ pm My child wakes up at _____ am
My child takes a nap from _____ to _____ and _____ to _____.

Educational Providers: Write N/A if your child does not attend school or daycare and move to the next section.
School Name: _____ Teacher's Name: _____
Address: _____
City, State, and Zip Code: _____
Telephone: _____ Fax: _____

My child's performance in school is: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
Would the educational provider do your child's feeding treatment if we trained them? _____
Does your child have an Individualized Education Program (IEP) or school-based interventions? _____
_____

Support Services:
Does your child and/or your family belong to any support groups? _____
Does your child and/or your family utilize any social services? _____
Do you feel you have adequate social supports surrounding your child's feeding difficulties? _____
_____

Other:
Are there any religious, spiritual, or cultural practices your family observes that may impact treatment? _____
Is yes, please provide more information: _____
_____
Does your child or family have any relevant legal issues that may impact treatment? _____
If yes, please provide more information: _____
_____

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.

Compliance
- ☐ Doesn't do what he/she is told
- ☐ Temper tantrums
- ☐ Verbal abuse/argues with others
- ☐ Hurts other people
- ☐ Throws things
- ☐ Bothers other people
- ☐ Breaks things
- ☐ Makes sounds or noises that bother people

Attention Deficits
- ☐ Is overactive
- ☐ Doesn't pay attention, but not overactive

Self-stimulation
- ☐ Body rocking
- ☐ Hand flapping

Somatic
- ☐ Complains of aches & pains
- ☐ Headaches
- ☐ Stomachache

Psychological
- ☐ Tics
- ☐ Phobias
- ☐ Separation anxiety
- ☐ Insists on everything being the same

Communication
- ☐ Doesn't know how to play with others
- ☐ Poor social skills
- ☐ Doesn't want to interact with people

Self-stimulation (continued)

- ☐ Nail biting
- ☐ Thumb sucking
- ☐ Masturbation
- ☐ Pica

Self-Injury

- ☐ Head-hitting
- ☐ Head-banging
- ☐ Arm/hand biting
- ☐ Eye gouging
- ☐ Pulls out own hair

Communication (continued)

- ☐ Communication delays or deficits
- ☐ Repeats what people say
- ☐ Speech doesn't make sense

- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Is there anything else about your child you would like us to know about your child? _____
_____
_____
_____

FOOD CHECKLIST

Child's Name: _____ Date: _____

Instructions: Please mark the box that best describes your child's experience with the food listed below. Please list the brand type/preferences, if applicable.
E= Eats this food consistently T= Has tried but refuses to eat W= Would like them to eat this food

Food	E	T	W	Food	E	T	W
Bagel				Eggs (Type: _____)			
Baked Potato				Fish sticks			
Biscuits				Fettuccini Alfredo			
Bread (Type: _____)				Grilled beef strips			
Brown & Wild Rice				Grilled chicken strips			
Cereal (Type: _____)				Ham			
Cream of Wheat (Type_____)				Ham Sandwich			
English Muffin				Ham & Cheese Sandwich			
French Toast				Hamburger			
French Fries				Hot dogs			
Grits				Italian (Beef) Meatballs			
Hash Browns				Lasagna			
Mashed Potatoes				Macaroni & Cheese			
Oatmeal (Flavor: _____)				Nuggets (Type: _____)			
Pancakes				PB&J Sandwich			
Rice Cereal				Peanuts			
Stuffing				Pistachios			
Sweet Potato				Pork Sausage			
Sweet Potato Fries				Pudding			
Tater Tots				Rice			
Toaster Strudel				Spaghetti O's			
Waffles				Tuna			
White Rice				Turkey Breast			
Almond				Turkey & Cheese Sandwich			
Bacon				Turkey Meatballs			
Beanie Weanies				Turkey Sausage			
Bologna Sandwich				Uncrustable (Type: _____)			
Cheese (Type: _____)				Veggie Burger			
Cheeseburger				Walnuts			
Chicken & Noodles				Yogurt (Flavor: _____)			
Chicken Breast				Beef Stew			
Chicken Broth				Beef Ravioli			
Chicken Noodle Soup				Beef-a-Roni			
Chicken Nuggets				Burrito (Type: _____)			

Food	E	T	W
Chicken Pot Pie			
Chili			
Enchilada (Type: _____)			
Macaroni & Beef			
Pizza (Brand/Toppings)			
Rice w/ Chicken & Vegetables			
Soup (Type: _____)			
Spaghetti & Meatballs			
Apple			
Apple Chips			
Apple Sauce			
Apricots			
Banana			
Banana Chips			
Blackberries			
Blueberries			
Fruit Cocktail			
Fruit Cup (Type: _____)			
Mandarin Oranges			
Mango			
Melon			
Peaches			
Pears			
Pineapple			
Raisins			
Raspberries			
Strawberries			
Asparagus			
Baked Beans			
Black Beans			
Broccoli			
Broccoli & Carrots			
Broccoli & Cheese			
Carrots			
Cauliflower			
Cauliflower & Cheese			
Chickpeas			
Corn			
Collard Greens			
Creamed Spinach			
Green Beans			
Okra (Fried or Canned)			
Peas			

Food	E	T	W
Peas & Carrots			
Pickles			
Spinach			
Squash (Butternut/Summer)			
Tomatoes			
Vegetable Medley			
Yams			
Zucchini			
Almond Butter			
BBQ Sauce			
Brown Sugar			
Butter			
Cashew Butter			
Cream Cheese			
Chocolate Syrup			
Dressing (Type: _____)			
Gravy (Type: _____)			
Honey			
Honey Mustard			
Jam/Jelly (Flavor: _____)			
Ketchup			
Marinara Sauce			
Mayonnaise			
Mustard			
Nutella (Hazelnut Spread)			
Peanut Butter			
Ranch			
Salsa			
Syrup (Type: _____)			
White Sugar			
Water			
Milk (%: _____)			
Cashew Milk (Type: _____)			
Chocolate Milk			
Soy Milk (Type: _____)			
Almond Milk (Type: _____)			
Orange Juice			
Apple Juice			
Cranberry Juice			
Grape Juice			
Carnation Instant Breakfast			

Instructions: Please indicate any additional foods not listed above that your child eats or you would like him/her to eat. Please provide type/brand preferences, if applicable.

Food	E	T	W	Food	E	T	W

FOOD DIARY

Instructions:

Complete a food diary each day for 3 days, offering your child foods/drinks as you typically would.

* For each meal/snack, indicate when the meal/snack started and ended.
* List ALL the specific foods offered and the brand, when applicable.
* Indicate the amount of each food your child consumed.

EXAMPLE

Child's Name: Sally

Date: 10/31/12

Mealtime	Foods Offered (Type, Brand, & Quantity)	Amount Consumed
5:45-6:15 AM	1 cup Welch's Grape Juice	1 cup
8:15-8:55 AM	4-ounce Yoplait Strawberry Yogurt	2 ounces
	1/2 of 1 Large Thomas Bagel 1 Tablespoon Philadelphia Cream Cheese	1/4 of bagel w/cream cheese
	1/2 cup Skim Milk	1/2 cup
11:15 AM-12:02 PM	Tyson Chicken Tender Strips 3 strips, cut into 1/4ths	2 strips
	1/2 cup green beans	none
	1/2 cup Horizon Organics Chocolate Milk	1/2 cup
11:56 AM - 12:35 PM	6 oz container of Raisins	2 raisins
6:30-6:45 PM	3 cups Welch's Grape Juice	3 cups
6:54-7:45 PM	1/2 of Hillshire Farms Turkey Sandwich with WonderBread (3 slices of turkey)	1 full slice of bread no turkey
	Small order McDonald's French Fries	entire order
	1 cup Aquafina Water	1 cup
8:09-8:29 PM	Jif Peanut Butter and Celery 2 Tablespoons, 2 Sticks	entire portion

Child's Name:

Date:

Mealtime	Foods Offered (Type, Brand, & Quantity)	Amount Consumed

Child's Name:

Date:

Mealtime	Foods Offered (Type, Brand, & Quantity)	Amount Consumed

Child's Name:

Date:

Mealtime	Foods Offered (Type, Brand, & Quantity)	Amount Consumed