Feeding Intensive Therapy Program Screener

1. What are your goals for a feeding intensive?

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2. Is your child safe to swallow at least one consistency?

- ❑ Yes
- ❑ No

3. Has your child had a Swallow Study?

- ❑ Yes
- ❑ No

If yes, what were the results? Please send a copy for a therapist to look over.

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4. Has your child had an Upper GI endoscopy or other GI tests?

- ❑ Yes
- ❑ No

If yes, what were the results? Please send a copy for a therapist to look over.

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5. Does your child have a feeding tube or receive supplemental feedings?

a. If yes, what kind? ____
b. What formula?____

c. Why do they receive supplemental feedings? Please check one.

- ❑ Poor endurance
- ❑ Poor oral motor skills
- ❑ Dysphagia
- ❑ Other ____

6. What gross motor milestones has your child achieved? Please check.

- ❑ Rolling
- ❑ Sitting
- ❑ Crawling
- ❑ Standing
- ❑ Walking

7. How would you describe their head control?

- ❑ Good
- ❑ Fair
- ❑ Poor

8. Can your child sit at the table (chair, high chair, wheelchair) for at least 5 minutes?

- ❑ Yes
- ❑ No

9. Are they showing interest in food if they are not currently eating by mouth?

- ❑ Yes
- ❑ No

10. Can you please provide the phone numbers and email addresses for specialists your child sees including GI, Cardiology, ENT, etc.?

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11. Please provide a copy of your child's growth chart.