Welcome to East Tennessee Children's Hospital's Motivating Mealtimes, our comprehensive feeding program. Your child has been referred for a comprehensive, multidisciplinary evaluation of feeding and swallowing skills. Your evaluation team may consist of a speech-language pathologist, occupational therapist, dietician, psychologist and/or social worker based on your child's individual needs. The purpose of this visit is to help identify what may be causing your child's difficulties with eating and to develop a plan toward improving his or her ability to enjoy positive mealtime experiences.

In order to help us prepare for your child's evaluation, we would like you to complete the forms listed below:

-Feeding History Form and food preferences list
-3 Day Food Log
-Pedi-EAT Questionnaire
-Ellyn Satter's Division of Responsibility Questionnaire (or sDOR.2-6y Questionnaire)

It is very important that the forms be filled out completely and returned to our office prior to your child's scheduled appointment. If you need to return the paperwork by mail, we have provided a self-addressed, stamped envelope. The forms may also be faxed or emailed to our office.

The 3 Day Food Log should be completed over 3 days in a row. You should include all liquids and solids that your child takes in by mouth as well as any tube feedings. It will be helpful to include as much information as possible so we may get a correct measure of your child's average calorie intake. An example is provided in the first box.

Your child's first appointment will take up to 2 hours. We will watch how you and your child interact during a meal. We want the mealtime to be as close to a mealtime at home as possible. We may watch from a one-way mirror or a video monitoring system so you and your child will not be interrupted during the meal. We would like your child to arrive hungry, but not uncomfortable. Please offer them water only up to 2 hours before your appointment so they will feel hungry when they arrive. If your child is on continuous tube feedings, please hold the feeding for 2 hours prior to your scheduled appointment time. We have a refrigerator, microwave, table and chairs, and highchairs in a kitchen-styled area available for your use. We would like you to bring the following:

- 2-3 foods of different textures
- 1 drink that your child enjoys
- 1-2 foods that your child refuses
- favorite cups/bottles/utensils
- any special formulas
- allergy-safe foods from home.

We look forward to working with you and your child.

865-541-8652 phone 865-693-3941 fax motivatingmealtimes@etch.com

EAST TENNESSEE Children's Hospital

Rehabilitation Services
Medical Office Building, Suite 130
2100 W. Clinch Ave., Knoxville, TN 37916
p. (865) 541-8652
f. (865) 693-3941

Motivating Mealtimes Feeding History Form

In your own words, tell us your concerns with your child's feeding skills.

List past medical history including birth history, hospitalizations, surgeries, or procedures.

Does your child have any food allergies or intolerances? If yes, please list.

Who lives in your home?

Does your child go to school or daycare? If yes, where and what grade?

What community resources do you have in place? (☐ TEIS, ☐ WIC, ☐ SSI, ☐ CSS, ☐ food stamps, ☐ other _____)

Do you have any concerns with other areas? If yes, check any that apply.

☐ Hearing ☐ Vision ☐ Speech/Language ☐ Motor Development ☐ Behavioral/Social

Is your child receiving other therapy services or have they in the past? If yes, please describe.

Does your child feed themselves?_____ What "utensils" are used at mealtimes? (Check all that apply below)

☐ Breast ☐ Bottle ☐ Sippy Cup ☐ Open Cup ☐ Straw ☐ Fingers ☐ Spoon ☐ Fork

Where is your child fed? (In a high chair? On your lap? At the table?)

Please describe how your child reacts to new or non-preferred foods (i.e. gags, leaves table, etc).

Please describe any negative behaviors your child has at mealtimes (i.e. screaming, throwing food, etc).

If your child has a feeding tube, please complete the following:

What type of feeding tube does your child have? _____ When was the tube placed? _____

Formula used in feeding tube? _____ Pump or gravity feeds used? _____

Please list schedule below with times/rate (continuous and/or bolus feedings)

Patient preferred food list

Please list the foods your child will eat at least 80% of the time below by category. Be very specific, if your child is particular about brands, containers, or how the food is presented (i.e. if your child will only eat Tyson's dinosaur chicken nuggets or only whole milk warmed in a bottle).

Proteins (i.e. Peanut butter on wheat bread only, bacon, eggs)	**Starches** (i.e. Kraft Mac & Cheese in the individual cups)	**Fruits/Vegetables** (i.e. freeze dried apples, peaches – fruit cup only)	**Drinks/Liquids** (i.e. Blue Gatorade, milk only in Dr. Brown's bottle warmed up)

Proteins	Starches	Fruits/Vegetables	Drinks/Liquids

Patient Name_____ Date of Birth _____ Date of Log _____

Time/Place/Setting Positioning	Food/Formula Offered (include formula recipe)	How much was eaten?	Comments (rate & volume if tube-fed)
Where: home	Great Value original applesauce	½ the cup	Mom fed with spoon
Who: mom, brother	Toast with butter	3 bites	fed himself
Position: highchair	1 scrambled egg	refused, gagged	
Start Time: 7:30 am	4 scoops Similac + 6 oz water	2 oz	Dr. Brown's bottle
Stop Time: 7:55 am	4 scoops Similac + 6 oz water	4 oz	Bolus 240mL/hour
Where:			
Who:			
Position:			
Start Time:			
Stop Time:			
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Stop Time:			

Patient Name________________________ Date of Birth ______________ Date of Log ____________

Time/Place/Setting Positioning	Food/Formula Offered (include formula recipe)	How much was eaten?	Comments (rate & volume if tube-fed)
Where:			
Who:			
Position:			
Start Time:			
Stop Time:			
Where:			
Who:			
Position:			
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Patient Name______________________________ Date of Birth __________________ Date of Log _______________

Time/Place/Setting Positioning	Food/Formula Offered (include formula recipe)	How much was eaten?	Comments (rate & volume if tube-fed)
Where:			
Who:			
Position:			
Start Time:			
Stop Time:			
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PEDIATRIC EATING ASSESSMENT TOOL (PediEAT)

Directions: We are interested in learning about the eating behaviors of your child. The items below may not apply to every child. When filling this out, think about what is typical for your child at this time.

PHYSIOLOGIC SYMPTOMS

	0	1	2	3	4	5	
My child...	Never	Almost Never	Sometimes	Often	Almost Always	Always	Score
1. gets watery eyes when eating	☐	☐	☐	☐	☐	☐	
2. gets red color around eyes or face when eating	☐	☐	☐	☐	☐	☐	
3. coughs during or after eating	☐	☐	☐	☐	☐	☐	
4. sounds gurgly or like they need to cough or clear their throat during or after eating	☐	☐	☐	☐	☐	☐	
5. sounds different during or after a meal (for example, voice becomes hoarse, high-pitched, or quiet)	☐	☐	☐	☐	☐	☐	
6. chokes or coughs on water or other thin liquids	☐	☐	☐	☐	☐	☐	
7. moves head down toward chest when swallowing	☐	☐	☐	☐	☐	☐	
8. has food or liquid come out of nose when eating	☐	☐	☐	☐	☐	☐	
9. gets pale or blue color around his/her lips during meals	☐	☐	☐	☐	☐	☐	
10. breathes faster or harder when eating	☐	☐	☐	☐	☐	☐	
11. needs to take a break during the meal to rest or catch their breath	☐	☐	☐	☐	☐	☐	
12. gets tired from eating and is not able to finish	☐	☐	☐	☐	☐	☐	
13. sweats/gets clammy during meals	☐	☐	☐	☐	☐	☐	
14. tilts head back while eating	☐	☐	☐	☐	☐	☐	
15. burps more than usual while eating	☐	☐	☐	☐	☐	☐	
16. throws up during mealtime	☐	☐	☐	☐	☐	☐	
17. throws up between meals (from 30 minutes after the last meal until the next meal)	☐	☐	☐	☐	☐	☐	
18. arches back during or after meals	☐	☐	☐	☐	☐	☐	

	0	1	2	3	4	5	
My child...	Never	Almost Never	Sometimes	Often	Almost Always	Always	Score
19. gags when it is time to eat (for example, when they see food or when placed in high chair)	☐	☐	☐	☐	☐	☐	
20. gags with smooth foods like pudding	☐	☐	☐	☐	☐	☐	
21. gags with textured food like coarse oatmeal	☐	☐	☐	☐	☐	☐	
22. gags, coughs, or vomits when brushing teeth (if your child does not have teeth, select Never. If your child will not allow you to brush his/her teeth, select Always)	☐	☐	☐	☐	☐	☐	
23. gets a bloated tummy after eating	☐	☐	☐	☐	☐	☐	
24. turns red in face, may cry with stooling	☐	☐	☐	☐	☐	☐	
25. has gas	☐	☐	☐	☐	☐	☐	
26. drools when eating	☐	☐	☐	☐	☐	☐	
27. has a hard time eating due to stuffy nose	☐	☐	☐	☐	☐	☐	
						Physiologic Symptoms Subscale Score	
If you would like to explain any of your responses, please do so here:							

PROBLEMATIC MEALTIME BEHAVIORS

	0	1	2	3	4	5	
My child...	Never	Almost Never	Sometimes	Often	Almost Always	Always	Score
28. avoids eating by playing or talking	☐	☐	☐	☐	☐	☐	
29. has to be told to start eating	☐	☐	☐	☐	☐	☐	
30. has to be reminded to keep eating	☐	☐	☐	☐	☐	☐	
31. won't eat at meals, but wants food later	☐	☐	☐	☐	☐	☐	
32. stops eating after a few bites	☐	☐	☐	☐	☐	☐	
33. refuses to eat	☐	☐	☐	☐	☐	☐	
34. shows more stress during meals than during non-meal times (whines, cries, gets angry, tantrums)	☐	☐	☐	☐	☐	☐	
35. likes something one day and not the next	☐	☐	☐	☐	☐	☐	

	0	1	2	3	4	5	
My child...	Never	Almost Never	Sometimes	Often	Almost Always	Always	Score
36. insists on food being offered in a certain way (such as, how food is on the plate or what dish or spoon is used, or where they sit)	☐	☐	☐	☐	☐	☐	
37. insists on being fed by the same person(s)	☐	☐	☐	☐	☐	☐	
38. becomes upset by the smell of food	☐	☐	☐	☐	☐	☐	
39. throws food or pushes food away	☐	☐	☐	☐	☐	☐	
40. prefers to drink instead of eat	☐	☐	☐	☐	☐	☐	
41. prefers crunchy foods	☐	☐	☐	☐	☐	☐	
42. eats better when entertained	☐	☐	☐	☐	☐	☐	
43. takes more than 30 minutes to eat	☐	☐	☐	☐	☐	☐	
44. needs mealtime to be calm	☐	☐	☐	☐	☐	☐	
45. wants the same food for more than two weeks in a row	☐	☐	☐	☐	☐	☐	
Items below are scored according to the numbers at right	5	4	3	2	1	0	
	Never	Almost Never	Sometimes	Often	Almost Always	Always	
46. likes to eat	☐	☐	☐	☐	☐	☐	
47. eats a variety of foods (fruits, vegetables, proteins, etc.)	☐	☐	☐	☐	☐	☐	
48. is willing to stay seated during mealtime	☐	☐	☐	☐	☐	☐	
49. opens their mouth when food is offered	☐	☐	☐	☐	☐	☐	
50. is willing to touch food with their hands	☐	☐	☐	☐	☐	☐	
					Problematic Mealtime Behaviors Subscale Score		

If you would like to explain any of your answers, please do so here:

SELECTIVE / RESTRICTIVE EATING

My child...	5 Never	4 Almost Never	3 Sometimes	2 Often	1 Almost Always	0 Always	Score
51. will eat mixed texture foods	☐	☐	☐	☐	☐	☐	
52. will eat food warmer than room temperature	☐	☐	☐	☐	☐	☐	
53. is willing to feed self (if younger in age, holds cup, feeds self crackers)	☐	☐	☐	☐	☐	☐	
54. keeps food in mouth when eating (food means non-liquids)	☐	☐	☐	☐	☐	☐	
55. keeps liquids in mouth when drinking	☐	☐	☐	☐	☐	☐	
56. keeps their tongue inside mouth during eating	☐	☐	☐	☐	☐	☐	
57. acts hungry before meals	☐	☐	☐	☐	☐	☐	
	5	4	3	2	1	0	
For the following items, if your child is younger than 15 months and is not offered these foods, select Always. If your child is over 15 months and not offered these foods or refuses to eat these foods, select Never.	Never	Almost Never	Sometimes	Often	Almost Always	Always	Score
58. will eat foods that need to be chewed	☐	☐	☐	☐	☐	☐	
59. will eat textured food like coarse oatmeal	☐	☐	☐	☐	☐	☐	
60. will eat frozen food, like ice cream	☐	☐	☐	☐	☐	☐	
61. chews their food enough	☐	☐	☐	☐	☐	☐	
62. moves food in their mouth when chewing without help	☐	☐	☐	☐	☐	☐	
Items below are scored according to the numbers at right	0	1	2	3	4	5	
	Never	Almost Never	Sometimes	Often	Almost Always	Always	Score
63. sniffs food or objects	☐	☐	☐	☐	☐	☐	
64. spits food out	☐	☐	☐	☐	☐	☐	
65. eats too fast	☐	☐	☐	☐	☐	☐	
						Selective / Restrictive Eating Subscale Score	

If you would like to explain any of your responses, please do so here:

ORAL PROCESSING

My child...	0 Never	1 Almost Never	2 Sometimes	3 Often	4 Almost Always	5 Always	Score
66. stores food in their cheek or roof of mouth	☐	☐	☐	☐	☐	☐	
68. gets food stuck in their cheek or roof of mouth	☐	☐	☐	☐	☐	☐	
70. prefers smooth foods like yogurt	☐	☐	☐	☐	☐	☐	
72. puts too much food in mouth at one time	☐	☐	☐	☐	☐	☐	
73. puts fingers in mouth to move food	☐	☐	☐	☐	☐	☐	
74. prefers strong flavors	☐	☐	☐	☐	☐	☐	
75. bites down on the spoon or fork and does not release it easily	☐	☐	☐	☐	☐	☐	
76. grinds teeth when awake (if your child does not have teeth, please select Never.	☐	☐	☐	☐	☐	☐	
77. chews on toys, clothes, or other objects	☐	☐	☐	☐	☐	☐	
Items below are scored according to the numbers at right	0	1	2	3	4	5	
For the following items, if your child is younger than 15 months and is not offered chewable foods, select Never. If your child is over 15 months and not offered these foods or refuses to eat these foods, select Always.	Never	Almost Never	Sometimes	Often	Almost Always	Always	Score
67. has to be reminded to chew food	☐	☐	☐	☐	☐	☐	
69. sucks on food to soften or moisten it, rather than chewing it	☐	☐	☐	☐	☐	☐	
71. chews food but doesn't swallow it	☐	☐	☐	☐	☐	☐	
74. chews a bite of food for a long time (~30 seconds or longer)	☐	☐	☐	☐	☐	☐	
						Oral Processing Subscale Score	

If you would like to explain any of your responses, please do so here:

This is a survey about feeding your preschool child 2 through 5 years old, asking what you do with feeding your child and how you think and feel about it. Please choose ONE response for each item.

		Always	Often	Sometimes	Rarely	Never
1	My family has meals at about the same times every day					
2	I let my child eat whenever s/he feels like eating.					
3	If I think my child hasn't had enough, I try to get him or her to eat a few more bites.					
4	When I am home at mealtimes, I sit down and eat with my child.					
5	I struggle to get my child to eat.					
6	I decide what foods to buy based on what my child eats.					
7	I let my child feed him/herself.					
8	I let my child eat until s/he stops eating and doesn't want more.					
9	I am comfortable with providing meals for my family.					
10	I make something special for my child when s/he won't eat.					
11	I let my child have drinks (other than water) whenever s/he wants them.					
12	We have food leftover after meals.					