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PARENT FOLLOW UP
FEEDING DISORDERS CLINIC
Neurodevelopmental Pediatrics
Confidential
Today's Date:

CHILD'S NAME:
DATE OF BIRTH/AGE:

SINCE YOUR LAST VISIT

Please list any questions or concerns you would like to discuss with the feeding team today:

How has your child's health been since the last feeding clinic visit?:

List any current therapy services:

Describe your child's appetite:

How long does an average meal last?:

Describe any negative or problematic behaviors you are seeing at mealtime:

Is your child having any vomiting/spitting up/ gastroesophageal reflux?:

How often is your child having a bowel movement and describe the consistency:

If you did not bring a food diary or log, please list average intake of each type of food/liquids consumed during a typical day. Also include approximate time of day and setting of each meal:

BREAKFAST:
Time:
Setting:
Foods and amounts:

SNACK:
Time:
Setting:
Foods and amounts:

LUNCH:
Time:
Setting:
Foods and amounts:

SNACK:
Time:
Setting:
Foods and amounts:

DINNER:
Time:
Setting:
Foods and amounts:

SNACK:
Time:
Setting:
Foods and amounts:

Thank you for your time!

The Neurodevelopmental Pediatrics Feeding Team