Food Range & Mealtime Assessment

MRN#:	
FOR OFFICE USE ONLY	

Protein	Carbohydrates/Starches	Fruits & Vegetables
2		
1		
5		
3		
)		
0		
1		
2		
3		
4		
5		
6		
7		
8		
0		
U		

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Mealtime Assessment

How does your child eat? ☐ Child feeds self ☐ Bottle fed	☐ Child is fed by pa☐ Breast Fed	arent/caregiver	☐ Uses fork, spo☐ Tube feed	on □Uses fingers □ Other
Where does your child ear	t most meals? Restaurants	☐ Schoo	ol	
Mealtime seating (select a ☐ Regular chair ☐ Parent/caregiver ☐ Other (please stat	☐ Highchair lap ☐ Adapted cha	☐ Booste air ☐ Wheel	_	t the table ts with family
Distractions present:	Music To	oys □Otl	her (please state):	
	☐ Cries or screar ← ☐ Leaves table b	- •	or throws food	☐ Messy eater
Mealtime schedule/routin *** Please indicate foods/liq nutritional supplements	uids typically consum	ed, as well as estin	nated quantities; als	so include
☐ No schedule, child☐ Breakfast: ☐ AM Snack: ☐ Lunch:	d grazes throughout o	day	☐ PM Snack: ☐ Dinner: _ ☐ Bedtime si ☐ Night feed	nack:
Please check if any of the	following occur dur	ing food or liquid	l intake:	
☐ Food/liquid comin☐ Noisy or trouble be☐ Falling asleep☐ Vomiting	~	☐ choking☐ Change in co☐ Gagging☐ Stiffening	☐ Coughing	5
Typical length of mea	ls:			
Sequence that food/	iquid is presented:			
Is child's weight appr		_	es 🗌 No	
Additional comments	about meal schedul	e/routine:	-	

*** IMPORTANT NOTE***

To ensure a thorough and accurate feeding assessment, please bring your child hungry. It is also recommended that you bring 2 preferred foods and 2 non-preferred foods to the evaluation.