



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.

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34769 (12/25)



Rehabilitation Services
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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)



Motivating Mealtimes
 motivatingmealtimes@etch.com
 p. (865) 541.8912
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Date: _____

Food Log

Name: _____ Date of Birth: _____ Date: _____

Time / Place / Setting Positioning	Food/Formula Offered (include formula recipe)	How much was eaten?	Comments (rate & volume if tube fed)	
EXAMPLE	Where: Home	Great Value original applesauce	1/2 the cup	Mom fed with a 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:			
	Where:			
	Who:			
	Position:			
	Start Time:			
	Stop Time:			
	Where:			
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	Stop Time:			
	Where:			
	Who:			
	Position:			
	Start Time:			
	Stop Time:			

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

Intended Use: The PediEAT is intended to assess observable symptoms of problematic feeding in children between the ages of 6 months and 7 years who are being offered some solid foods. The PediEAT is intended to be completed by a caregiver who is familiar with the child's typical eating. This is most often a parent, but may be another primary care provider.

Disclosure: The PediEAT does not replace a healthcare provider's clinical assessment. The PediEAT is also not intended to provide a diagnosis, but instead may provide the health care provider with an objective assessment of the child's eating in order to facilitate diagnosis and treatment decisions.

Terms of Use: You may use the PediEAT for clinical practice or research, but you may not alter, distribute, share, or adapt the PediEAT for electronic medical charting or other digital use without permission from the authors. The PediEAT is protected by U.S. copyright law. Full terms of use below.

Referencing Information: Please give appropriate credit to the authors when presenting, publishing, or otherwise referencing the Pediatric Eating Assessment Tool (PediEAT).

Thoyre, S., Pados, B., Park, J., Estrem, H., Hodges, E., McComish, C., Van Riper, M., and Murdoch, K. (2014). Development and content validation of the Pediatric Eating Assessment Tool (Pedi-EAT). *American Journal of Speech-Language Pathology*, 23, 1-14. doi: 10.1044/1058-0360(2013/12- 0069)

Thoyre, S., Pados, B., Park, J., Estrem, H., McComish, C., Hodges, E. (2018). The Pediatric Eating Assessment Tool: Factor structure and psychometric properties. *Journal of Pediatric Gastroenterology and Nutrition*, 66(2), 299-305. doi: 10.1097/MPG.0000000000001765

Pados, B.F., Thoyre, S.M., & Park, J. (2018). Age-based norm-reference values for the Pediatric Eating Assessment Tool. *Pediatric Research*, 84(2), 233-239. doi:10.1038/s41390-018-0067-z

Note: The PediEAT and the PediEAT 10-item Screeners are not in any way associated with the PEDI-EAT-10 by Soyer et al., 2017 or Arsian et al., 2018.

PLEASE CHECK THE FEEDING FLOCK TEAM WEBSITE FOR UPDATES:

www.feedingflockteam.org



PEDIATRIC EATING ASSESSMENT TOOL (PediEAT)

Terms of Use

The PediEAT is available for your non-commercial use in clinical practice, education, and research. The PediEAT is protected by copyright. Your right to use of the PediEAT is limited to your personal, non-commercial use in accordance with the terms and conditions below.

By using the Pediatric Eating Assessment Tool (PediEAT), you have agreed to the following terms of use:

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- ✓ You acknowledge and agree that you may not alter the PediEAT in any way or create any derivative work from it, including translating the tool into other languages, without the prior written approval from the author(s) of the tool.
- ✓ You agree to use the PediEAT solely as intended (as set forth on the front page of the tool).
- ✓ You acknowledge and agree that the PediEAT is not a diagnostic tool and it does not replace a healthcare provider's assessment.
- ✓ You agree that the PediEAT is being provided "as is" and that neither the Feeding Flock Team nor any of the authors of the tools make any warranty with respect to the tool.
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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							
My child...	Never	Almost Never	Some times	Often	Almost Always	Always	Score
1. gets watery eyes when eating	0	1	2	3	4	5	
2. gets red color around eyes or face when eating	0	1	2	3	4	5	
3. coughs during or after eating	0	1	2	3	4	5	
4. sounds gurgly or like they need to cough or clear their throat during or after eating	0	1	2	3	4	5	
5. sounds different during or after a meal (for example, voice becomes hoarse, high-pitched, or quiet)	0	1	2	3	4	5	
6. chokes or coughs on water or other thin liquids	0	1	2	3	4	5	
7. moves head down toward chest when swallowing	0	1	2	3	4	5	
8. has food or liquid come out of nose when eating	0	1	2	3	4	5	
9. gets pale or blue color around his/her lips during meals	0	1	2	3	4	5	
10. breathes faster or harder when eating	0	1	2	3	4	5	
11. needs to take a break during the meal to rest or catch their breath	0	1	2	3	4	5	
12. gets tired from eating and is not able to finish	0	1	2	3	4	5	
13. sweats/gets clammy during meals	0	1	2	3	4	5	
14. tilts head back while eating	0	1	2	3	4	5	
15. burps more than usual while eating	0	1	2	3	4	5	
16. throws up during mealtime	0	1	2	3	4	5	
17. throws up between meals (from 30 minutes after the last meal until the next meal)	0	1	2	3	4	5	
18. arches back during or after meals	0	1	2	3	4	5	
19. gags when it is time to eat (for example, when they see food or when placed in high chair)	0	1	2	3	4	5	
20. gags with smooth foods like pudding	0	1	2	3	4	5	



PEDIATRIC EATING ASSESSMENT TOOL (PediEAT)

My child...	Never	Almost Never	Some times	Often	Almost Always	Always	Score
21. gags with textured food like coarse oatmeal	0	1	2	3	4	5	
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")	0	1	2	3	4	5	
23. gets a bloated tummy after eating	0	1	2	3	4	5	
24. turns red in face, may cry with stooling	0	1	2	3	4	5	
25. has gas	0	1	2	3	4	5	
26. drools when eating	0	1	2	3	4	5	
27. has a hard time eating due to stuffy nose	0	1	2	3	4	5	
PHYSIOLOGIC SYMPTOMS SUBSCALE SCORE							

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



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My child...	Never	Almost Never	Some times	Often	Almost Always	Always	Score
39. throws food or pushes food away	0	1	2	3	4	5	
40. prefers to drink instead of eat	0	1	2	3	4	5	
41. prefers crunchy foods	0	1	2	3	4	5	
42. eats better when entertained	0	1	2	3	4	5	
43. takes more than 30 minutes to eat	0	1	2	3	4	5	
44. needs mealtime to be calm	0	1	2	3	4	5	
45. wants the same food for more than two weeks in a row	0	1	2	3	4	5	
Items below are scored from 5 to 0							
46. likes to eat	5	4	3	2	1	0	
47. eats a variety of foods (fruits, vegetables, proteins, etc.)	5	4	3	2	1	0	
48. is willing to stay seated during mealtime	5	4	3	2	1	0	
49. opens their mouth when food is offered	5	4	3	2	1	0	
50. is willing to touch food with their hands	5	4	3	2	1	0	
PROBLEMATIC MEALTIME BEHAVIORS SUBSCALE SCORE							

SELECTIVE / RESTRICTIVE EATING							
My Child...	Never	Almost Never	Some times	Often	Almost Always	Always	Score
51. will eat mixed texture foods	5	4	3	2	1	0	
52. will eat food warmer than room temperature	5	4	3	2	1	0	
53. is willing to feed self (if younger in age, holds cup, feeds self crackers)	5	4	3	2	1	0	
54. keeps food in mouth when eating (food means non-liquids)	5	4	3	2	1	0	
55. keeps liquids in mouth when drinking	5	4	3	2	1	0	
56. keeps their tongue inside mouth during eating	5	4	3	2	1	0	



PEDIATRIC EATING ASSESSMENT TOOL (PediEAT)

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"							
My child...	Never	Almost Never	Some times	Often	Almost Always	Always	Score
58. will eat foods that need to be chewed	5	4	3	2	1	0	
59. will eat textured food like coarse oatmeal	5	4	3	2	1	0	
60. will eat frozen food, like ice cream	5	4	3	2	1	0	
61. chews their food enough	5	4	3	2	1	0	
62. moves food in their mouth when chewing without help	5	4	3	2	1	0	
Items below are scored from 0 to 5							
63. sniffs food or objects	0	1	2	3	4	5	
64. spits food out	0	1	2	3	4	5	
65. eats too fast	0	1	2	3	4	5	
SELECTIVE / RESTRICTIVE EATING SUBSCALE SCORE							

ORAL PROCESSING							
My child...	Never	Almost Never	Some times	Often	Almost Always	Always	Score
66. stores food in their cheek or roof of mouth	0	1	2	3	4	5	
67. gets food stuck in their cheek or roof of mouth	0	1	2	3	4	5	
68. prefers smooth foods like yogurt	0	1	2	3	4	5	
69. puts too much food in mouth at one time	0	1	2	3	4	5	
70. puts fingers in mouth to move food	0	1	2	3	4	5	
71. prefers strong flavors	0	1	2	3	4	5	
72. bites down on the spoon or fork and does not release it easily	0	1	2	3	4	5	
73. grinds teeth when awake (if your child does not have teeth, please select Never.	0	1	2	3	4	5	



PEDIATRIC EATING ASSESSMENT TOOL (PediEAT)

74. chews on toys, clothes, or other objects	0	1	2	3	4	5	
For the following items, if your child is younger than 15 months <u>and</u> 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"							
My child...	Never	Almost Never	Some times	Often	Almost Always	Always	Score
75. has to be reminded to chew food	0	1	2	3	4	5	
76. sucks on food to soften or moisten it, rather than chewing it	0	1	2	3	4	5	
77. chews food but doesn't swallow it	0	1	2	3	4	5	
78. chews a bite of food for a long time (~30 seconds or longer)	0	1	2	3	4	5	
ORAL PROCESSING SUBSCALE SCORE							

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

Scoring Summary

Scores are assigned to the PediEAT items with low scores indicating no problems and high scores indicating more problematic behaviors. In each subscale, there are numbers which indicate the score assigned to each response in that subscale. Note that the scores may change between the subscales. For example, the scores assigned to the responses in the Physiologic Symptoms subscale go from 0 (Never) to 5 (Always) while the scores assigned to the responses in the Selective / Restrictive Eating subscale go from 5 (Never) to 0 (Always). Also note that within the Problematic Mealtime Behaviors subscale and the Selective / Restrictive Eating subscale, there are a subset of items at the bottom that are scored differently than the other items in that subscale.

To calculate the subscale score, sum the score from each item in that subscale. Copy the subscale scores to the table below. To calculate the total score, sum all the subscale scores.

Subscale	Score
Physiologic Symptoms	
Problematic Mealtime Behaviors	
Selective / Restrictive Eating	
Oral Processing	
Total Score	

Please see the scoring guidelines for interpretation of the score using percentiles and T-scores.

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.					