

Alaska Speech & Hearing Clinic

2401 E. 42nd Ave., Suite #101

Anchorage, AK 99508

(907) 562-4550 / (907) 562-4554 – Fax

Name _____ DOB _____

There is significant medical history. It is important that we know the full medical background so please send any and all reports that you have available. We can make copies here and give the originals back to you if needed. Please answer the below shown questions as best you can.

What will your child eat? _____

What are your child's favorite foods? _____

What is the tastiest textures child will eat? _____

What are the textures your child does not like? _____

What are your Oral-Motor concerns? _____

Will your child use the follow containers/implements? **Check only if YES** ✓

Bottle _____ Sippy Cup _____ Regular Cup _____ Straw _____

Spoon _____ Fork _____ Finger food _____

COMMENTS: