St. Joseph's Pediatric Feeding and Swallowing Center

Child's Name: _____

Before Intervention

Please log for 7 days in a row before coming for your evaluation & bring with you the day of the evaluation

		Stool Amount			**Stool Consistency**			**Child's Behaviors**				
Date	Time	Small	Medium	Large	Watery	Soft/Mushy	Hard/Pellet	Red Face	Crying	Grunting	Straining	Squatting
4/26/2010	10:00 a.m.	x					x	x	x	x	x	