PEDIATRIC FEEDING HISTORY FORM

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

1. Please explain, in your own words, what your child's current feeding problem is:

2. Was your child breastfed? From when to when _____

   Was your child bottle-fed? From when to when _____

Please describe your child's initial skill on the breast and/or bottle:

3. During these early feedings, did your child frequently arch, cry, spit up, gag, cough, vomit or pull off the nipple?
   Circle the behaviors shown and describe when they would happen, why, and for how long:

4. Describe how the weaning process off the breast and/or bottle went and why the child was weaned:

5. At what age was your child introduced to Baby cereal? _____ Baby food? _____

   Finger foods? _____ Table food? _____

When did they Transition fully to table food? _____

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Please describe how these transitions were handled by your child, especially if any difficulties happened:

IF YOUR CHILD EATS BY MOUTH, PLEASE ANSWER THE FOLLOWING QUESTIONS:

6a. List the foods that your child currently will eat and drink (put a star next to their favorites):

6b. List the foods your child refuses:

6c. List the foods your child is allergic to:

6d. Describe your child's mealtime:

Who typically feeds your child? _____

Who typically eats with your child? _____

What type of chair is used? _____

How long are meals typically? _____

Does your child use utensils or any type of special cups/bowls (describe)? _____

Are there any other activities going on at meals? What activities (describe)? _____

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6e. What times does your child typically eat and what type (bottle, breast, solids)?

Time	Breast	Bottle	Solids (baby food; table?)

IF YOUR CHILD IS *TUBE-FED*, PLEASE ANSWER THE FOLLOWING QUESTIONS:

7a. What formula is used and how do you mix it?

7b. Describe where your child is tube fed and what activities are occurring at the same time:

7c. Describe your child's reactions to the tube feedings (connecting, during, disconnecting):

7d. Please detail your child's feeding schedule below.

Time of feeding (Start time)	NG, G, or Continuous	Amount	Gravity or Pump	Over what period or at what rate

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***PLEASE ANSWER FOR ALL CHILDREN**

8. Has your child ever been on any type of special diet other than what you just described (circle 1)? **YES NO**

   If yes, please describe the type of diet, at what age, why, and what was your child's response:

9. How do you know your child is hungry or full?

   Hungry?

   Full?

10. How much has your child lost or gained weight in the last 6 months?

11. Would you describe your child's weight as (circle one): Ideal Underweight Overweight

12. Does your child have/had any of the following problems (circle which ones)? Please describe:
    Dental, frequent constipation, frequent diarrhea, vomiting, choking, gagging, coughing.

13. Does your child take a vitamin supplement? Which one?

14. Describe how you and your child feel after a feeding:

    You:

    Your child:

15. What other evaluations have been completed regarding your child's feeding difficulties and what were the results/what were you told?

16. What treatments have been tried for this problem, and what were the results?

17. How can we be most helpful to you and your child?

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MEDICAL HISTORY

Please answer as completely and accurately as possible.

Child's Physician or Health Care Providers (including Primary Care Physician):

Name: _____ Profession: _____ Phone: _____

Address: _____

Name: _____ Profession: _____ Phone: _____

Address: _____

Date of Child's Last Medical Checkup: _____ Height: _____ Weight: _____

Is your child in good health at present?

Are there any medical precautions the therapist should be aware of when working with your child?

People Living in this Child's household:

Name	**Age**	**Sex** (circle one)	**Relationship to Child**
		M F	
		M F	
		M F	
		M F	

If both primary caregivers work, who cares for the child?

Name:

Phone# :

Address:

When is the child in this childcare?

What language(s) is/are spoken at home?

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FAMILY STRESSORS (please note if any of the following stressful events happened **in the last 12 months**)

NO	YES	EVENT	EXPLANATION
		Marital separations/divorce	
		Death in the family	
		Financial crisis	
		Job change/difficulties	
		School problems	
		Legal problems	
		Medical problems	
		Household move	
		Extended separation from parents	
		Other stressful events	

FAMILY ADAPTATION

How would you describe your child's general adjustment at home?_____Poor __Fair ____Good

How does your child get along with each member of the family?

Parent A

_____

Parent B

_____

Siblings

_____

Have there been any traumatic family events during this child's development?

Have there been any specific events or traumas linked with the onset of your child's difficulties?

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Pregnancy and Birth History

PRENATAL HISTORY:

Did the mother receive prenatal care? Yes_____ No_____ (If no, please explain):

Were there any pregnancy complications (e.g., Pre-eclampsia, Gestational Diabetes, Bed Rest)?
Yes_____ No_____ (If yes, please explain):

Was the child delivered full-term? Yes_____ No_____ (If no, at what week)

Was the birth vaginal or C-Section?

Were there any complications at birth (e.g., lack of oxygen, low APGAR scores)? Yes____ No____
(If yes, please explain):

HOSPITALIZATIONS AND/OR SURGERIES:

Please list the dates of any hospitalizations your child has had and the reason. List the dates of any surgeries your child has had and the reason.

1.

2.

3.

4.

Are there any medical diagnoses? Please list the diagnosis, date, and diagnosed and by whom:

Does the child have a history of ear infections? **YES OR NO** If yes, how were they treated (meds, tubes, etc.)?

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Has the child's hearing been evaluated? **YES OR NO** If so, what were the results?

Has your child's vision been evaluated? When and by whom? What were the results?

Any allergies to food, or environmental items we should know about? Yes_____ No_____ (If yes, please list the items):

MEDICATIONS

List any medications your child has consistently used **in the past:**

Medication:_____Purpose:_____When Taken: _____

Medication:_____Purpose:_____When Taken: _____

Medication:_____Purpose:_____When Taken: _____

List any medications your child is **currently** taking:

Medication:_____Purpose:_____Frequency of dosage: _____

Medication:_____Purpose:_____Frequency of dosage: _____

Medication:_____Purpose:_____Frequency of dosage: _____

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Please note any illnesses for which your child is currently being treated:

Has your child received any therapy services in the past (List dates and type of therapy)?

Does your child interact appropriately with children the same age? Yes_____ No_____

Does your child have any behavioral issues that are a problem? Yes_____ No_____

Describe items your child finds reinforcing (food, stickers, TV characters, etc.)

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Family Medical History

Are there any of the following medical problems on either side of the child's BIOLOGICAL parents' families? If YES, please indicate which side of the family, MOTHER or FATHER, and explain WHO this is about the CHILD. Please also explain if medications, surgery, or hospitalizations were needed.

NO	YES	DESCRIPTION	MOTHER OR FATHER'S SIDE?	WHO (as related to your child)	EXPLANATION
		Birth defects/Congenital disorder	Mother's Father's		
		Neurological disorders or seizures (e.g. Alzheimer's, Parkinson's)	Mother's Father's		
		Respiratory disease or tuberculosis (e.g., Asthma, COPD)	Mother's Father's		
		Hormonal or Gland disorder (e.g., Hypothyroidism, pituitary tumor)	Mother's Father's		
		Allergies- food or environmental (Specify which type and for whom)	Mother's Father's		
		Diabetes (Type 1 or 2)	Mother's Father's		
		Stomach disease/disorder/problems (e.g., Reflux, Colitis, Chron's, Celiac)	Mother's Father's		
		Senses problems- vision, hearing, touch, taste, smell, balance	Mother's Father's		
		Swallowing or feeding problems (e.g., Described as a picky eater as a child, esophageal strictures)	Mother's Father's		

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		Attentional/learning problems	Mother's Father's		
		Hyperactivity	Mother's Father's		
		Developmental therapy (e.g., Speech therapy, Physical therapy)	Mother's Father's		
		Alcohol/drug problems	Mother's Father's		
		Psychological/nervous issues	Mother's Father's		

NOTES OR ADDITIONAL INFORMATION:

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