Feeding Evaluation Case History Form

Child's Name:_____ Date of Birth: _____ Current Age: _____

Person Completing Form & Relationship to patient:_____ Date:_____

The following information will be read by the therapist who is performing the initial work with your child. It will help us to perform the best tests for your child. Your opinion and information is very helpful. Please complete this form and bring it with you to the first session. We will ask you to complete this information at the first visit if you are not able to complete it prior to the session.

Your Requests and Opinions:

1. What is the reason your child is scheduled for this test? _____
2. What do you want from this evaluation?_____
3. Are there any customs, religious beliefs, or wishes that might affect our care of your child? If yes, please explain._____
4. If you are asked to learn home exercises to practice with your child, which method of instruction do you prefer? (Check all that apply)

   ___pictures ____written ___demonstration ___no preference

5. Please list any other concerns that you have._____

Please list the therapies/feeding programs your child currently receives or has received in the past and where they receive them._____

BIRTH INFORMATION:

1. Was your child born after a full term pregnancy? ___yes ___no
   If no, how early?_____ Child's Birth Weight ___lbs.___oz.
2. Were there any complications during pregnancy? ___yes ___no **If so, please describe.**
3. Were there complications during delivery? ___yes ___no **If so, please describe.**
4. Did your child stay in the hospital after birth, for any length of time? ___yes ___no **If so, why and for how long?**
5. Was your child on mechanical ventilation after birth? ___yes ___no **If so, why and for how long?**

MEDICAL

Is your child allergic to any medicines or foods? Please list?_____

Please list all the doctors that your child sees and for what reasons?_____

What medical condition(s), does your child have?_____

Please list the prescription medications that your child is currently taking:_____

What precautions or concerns do you want us to know about?_____

ILLNESSES

Please check if your child has had any of the following:

____hospitalization
____pneumonia
____always congested
____ floppy airway
____cleft lip/palate
____allergic reactions
____stridor/noisy breathing
____turned blue/quit breathing
____ constipation
____surgeries
____tonsillitis
____frequent colds
____tracheostomy
____heart problems
____head injury
____reflux
____cancer/tumor
____ ear infections
____bronchoscopy
____vascular ring
____seizures
____tracheoesophageal fistula
____respiratory syncytial virus (RSV)
____failure to thrive
____bronchitis/bronchiolitis
____upper respiratory infections
____breathing treatments
____mechanical ventilation
____infection(meningitis, encephalitis)

If any checked, please explain:_____

FEEDING HISTORY

1. Has your child had a swallow study or feeding evaluation before this appointment? If so, when: _____
   Where:_____ Results:_____
   Recommendations:_____
2. What does your child eat/drink?

____thin liquids (juice, water, milk)
____thickened liquids (circle one: nectar/syrup, honey thick, milkshake thick)
____Food: (circle one or more: stage 1, stage 2, stage 3, mashed soft table food, regular table food)
____Drink method: (circle what is used: bottle, breast, sippy cup, open cup, straw, special method)
____Food method: (circle what is used: spoon, finger foods, fork, special equipment)

Please explain any problems related to feeding related to above checked:
_____

What foods/liquids and how much does your child usually eat for:
Breakfast

Lunch

Dinner

Snacks

3. Does your child have any of the following behaviors during feeding?

____crying ____gagging ____vomiting _____spitting food out/refusing food ____coughing
____congestion ____gurgly, wet voice sounds _____sneezing & runny eyes _____breathing problems
____color changes _____OTHER

If any checked, please explain:_____

4. How long does a meal time last for your child? _____
5. Which types of foods are easiest for your child? _____
6. Which types of foods are hardest for your child? _____

SENSORY

Does your child mind having his face, hands, feet messy or dirty? ___Yes ___No
If yes, please describe _____

	YES	NO
Does your child tolerate: Toothbrushing	_____	_____

Having face/hands wiped _____ _____
Having toenails/nails clipped _____ _____
Having haircut _____ _____

FOR CHILDREN WITH G-BUTTONS:

What is your child receiving via g-button? _____

How often and how much at a time? _____

How fast is volume given? _____

What is child's reaction to g-button feeds? _____