FAMILY SPEECH & THERAPY SERVICES

Client History Form for Feeding

Date: _____

Name: _____ DOB:_____ Age:_____

Diagnoses (of any kind): _____

Parents Names: _____

Was this evaluation recommended by another professional? Yes_____ No_____

If yes, by who, and what concerns were shared with you?_____

_____

When did you first notice a problem? _____

Is your child followed by any other medical professional? Yes_____ No_____

If yes, by whom? _____

Birth History

Please check yes or no for the following questions. After each question, please write in any comments that you feel would be helpful to us.

	YES	NO	Comments
Were there any illnesses injuries, bleeding or any other difficulties before birth? Please specify.			
Was your child born prematurely or significantly past the due date? If yes, please give weeks.			
Was the delivery breech, caesarean, or other? Please specify			
Were there any complications with labor or delivery? If yes, please specify			
Was there a need for oxygen or additional respiratory assistance?			
Were there complications at birth such as jaundice, limpness, etc.?			
Were there any feeding difficulties while in the hospital?			
Was the length of your infants say in the hospital unusually long? If yes, why?			
Has your child ever had their hearing tested? If yes, please list date of test and results			

Birth Height: _____ Weight:_____

MEDICAL HISTORY

It is very important to have as complete of medical history for your child as possible. Please fill out the grid below, making sure you include an explanation for any questions answered "yes". In your explanation, please include your child's age(s) if relevant, any diagnosis made, and any treatments that have occurred.

DESCRIPTION	YES	NO	Comments
Frequent colds/respiratory illness			
Frequent strep throat/sore throat			
History of Aspiration			
Frequent ear infections (tubes?)			
Birth defect/genetic disorder			
Lung condition/respiratory disorder			
Allergies or asthma			
Heart condition			
Kidney/renal disorder			
Urinary problems/infections			
Muscle disorder/muscle problem			
Neurological disorder			
Seizures or convulsions			
Stomach disorder/stomach pain			
Vomiting/digestion problems			
Failure to gain weight/feeding problems			
Sleeping difficulties			
Constipation/diarrhea problems			
Dehydration episodes			
Head injuries or concussions			
Ingestion of toxins, poisons, foreign objects			
Major medical procedures (details below)			
Chronic medications (for what? When?)			
Any major childhood illness (pox, croup, measles, mumps, meningitis, etc)			
Medical conditions not mentioned above			

PRESENT HEALTH STATUS:

Most recent Height: _____ Weight:_____ Date: _____

Please note any illnesses for which the client in currently being treated, including their current medications: _____

_____

_____

Please list previous therapy services including previous feeding therapies:

_____

_____

Current therapy services:

_____

_____

FAMILY HISTORY

Please list people who reside within the home and ages of siblings:

_____

_____

Are there any family circumstances you feel we should know about? (e.g, new baby, divorce, separation, recent death in the family)

_____

DEVELOPMENTAL HISTORY

1. **How old was your child when he/she:**

Sat unassisted	
Crawled	
Walked	
Said first word	
Combined words	
Begin eating Baby Cereal	
Begin eating baby food.	
Begin to eat finger foods	
Transition fully to table foods	
Use fork/spoon	
Drink from a straw	
Drink from an open cup	
Stop using pacifier	
Stop using sippy cup	

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

_____

_____

_____

FEEDING HISTORY:

1. Please explain, in your own words, your child's current difficulties with eating and drinking. When did the current difficulties with eating and drinking begin? Describe.

_____

_____

_____

_____

2. Was your child breast fed? _____ From when to when? _____

Was your child bottle fed? _____ Breast milk or formula?_____

From when to when? _____Type of formula used_____

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

_____

_____

_____

_____

3. Describe how the weaning process from the breast and/or bottle went and why your child was weaned:

_____

_____

5. Has your child ever been on any type of special diet (other than previously described)? _____

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

_____

_____

_____

_____

6. During the early feedings did your child frequently arch, cry, spit up, gag, cough, vomit or pull off? List any behaviors you saw and describe when they would happen, why, and for how long:

_____

_____

_____

_____

7. Does your child have food preferences based on color, shape, flavor or temperature? (sweet, salty, sour)? Do they tend to fixate on one particular brand of food? (ex. only eats Mcdonalds chicken nuggets.) If yes, please explain:

_____

_____

8. Has the child lost gained weight suddenly? Explain.

_____

_____

9. Does your child have difficulties with any of the following? Describe

DESCRIPTION	YES	NO	COMMENTS
Drooling			
Snoring/Mouth Breathing			
Voluntary opening/closing of the mouth			
Sucking			
Thumb sucking, digit sucking			
Extended pacifier use			
Keeping food in mouth			
Chewing			
Biting on a nipple, cup or utensils			
Drinking from a cup or bottle			
Eating from a spoon			
Major mood swings			
Swallowing (food, liquid, medications)			
Choking/gagging			
Reflux			
Tooth Grinding			
Frequent mouthing/eating non edibles			
Chewing on non edibles (fingernails, toys, straws, tongue, pens/pencils/others)			

8. Does your have any other feeding preferences or aversions not mentioned above? If yes, please explain:

_____

_____

_____

MEALTIME:

1. Describe your child's meal time routine? Who is with the child during meal time?

_____

2. Where and how is the child positioned when eating and drinking (chair, bed, highchair)?

3. If your child attends daycare or school please describe their mealtime routines in this environment?

4. What feeding/eating drinking methods does the child use (eg. breast, bottle, g-tube, spoon, cup) describe the cup (straw, cut out cup, spouted cup, regular open cup.)

5. Does the child use any specialized equipment when eating or drinking?

6. Is your child able to utilize food utensils efficiently?

7. Please describe your child's appetite:

8. How long does a typical meal last?

9. Does the child eat enough food and drink enough liquid in a reasonable amount of time? Yes / No

Approximate Amount 1. Liquids_____

2. Solids _____

11. Are there smells of certain foods that bother your child?

_____

_____

_____

12. What is your child's response when presented with a food item he or she does not like?

_____

_____.

13. Has the client had problems with any of the following (beyond expected for child's age):

DESCRIPTION	YES	NO	COMMENTS
Bed wetting			
Temper tantrums			
Head banging			
Breath holding			
Aggression/destructiveness			
Nervous habits (nail biting, etc)			
Major mood swings			

14. What other evaluations have been completed and what were the results, or what were you told?

_____

_____

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

_____

_____

16. Please take time to record your child's intake of food for one day (prior to the evaluation date) in the chart below. Be sure to include quantity of food and liquids.

Breakfast	
AM snack	
Lunch	
PM snack	

Dinner	
PM snack	

17. If there anything else you feel would help us better prepare for your child's evaluation, please let us know:

_____

_____

_____

_____

_____

_____

_____

IF YOUR CHILD IS TUBE FED, PLEASE ANSWERE THE FOLLOWING QUESTIONS:

1a. What type of formula is used and how is it mixed (e.g., pre-blended, blender)?

_____

_____

1b. Please detail your child's feeding schedule below.

Time of Feeding (start time)	NG, G or Continuous	Amount	Gravity or Pump	Over what time period or what rate

1c. Describe where your child is tube fed and what activities are occurring at the same time:

1d. Describe your child's reactions to the tube feedings (connecting, during, discontinuing):

1e. Has your child been cleared by their physician to eat orally? If possible please attach medical documentation such as reports from video swallow study or other feeding evaluations.

Parent's Signature Date