CentraState Medical Center ®

Pediatric History ï Feeding Evaluation

Full name of child:		Date of Birth		Male/Female
Chronological Age		Who referred for evaluation		Language
Parent/Guardian Name #1		Occupation		
Parent/Guardian Name #2		Occupation		
Address			Email	
Name of person providing information		Relationship		
With whom does the child live?				
Phone numbers	Home:		Cell:	

Current concerns and background information

1. Has your child ever been seen by another specialist e.g. gastroenterologist, nutritionist, or feeding therapist for feeding difficulties? Yes _____No _____

2. Has your child ever had a swallow study done? Yes_____ No_____

   If yes, when and where? _____

   Why was the child referred for the assessment? _____
   _____

3. Has your child been seen by a physician at CentraState Medical Center?
   Yes _____No_____

   If yes, when and with whom?_____

4. Has your child been seen by a neurologist? Yes _____No_____

   If yes, when and with whom?_____

5. Has your child ever been seen by a neurodevelopmental pediatrician?
   Yes _____No _____

   If yes, when and with whom? _____

6. Has a professional ever given you a specific diagnosis for your child?

_____

Please check all that apply.

Bronchopulmonary dysplasia		Chronic lung disease		Cerebral palsy	
Congenital lung disease		Developmental delay		Down syndrome	
Failure to thrive		Hearing problems		Hydrocephalus	
Poor weight gain		Prematurity		Seizure disorder	
Tracho/laryngo malacia		Tracheostomy		Vision problems	
Vocal cord paralysis/paresis		Congenital heart disease		Cleft lip/palate	
Sensory integration dysfunction		Autism		scoliosis	
Other					

7. Child's weight _____Percentile _____Date last taken _____

8. Child's height _____ Percentile _____Date last taken _____

9. Does your child have allergies? Yes _____No_____Unknown _____

If yes, please describe _____

_____

10. Has your child ever had any illnesses or diseases ? _____

Asthma		Bronchitis		Dyhydration	
Gastroesophagel reflux		Gastrostomy		NISSEN fundo.	
Pneumonia		PE tubes		RSV	
Other					

11.What do you think contributes to your child's feeding difficulties? _____

_____

_____

12. What are the main questions you want to address during the Feeding Team Evaluation?_____

_____

13. In addition to the stress you may have related to your child's feeding problems, are there other significant stressors that you or members of your family have experienced within the past year? Yes _____No_____

Describe: _____

14. Are there any foods that your child has difficulty with or is unable to eat

Yes _____ No_____

If yes, specify:

Liquids: _____

Baby foods: _____

Third stage/lumpy _____

Soft chewable solids (e.g. pastas, cooked vegetables, canned fruit) _____

_____

Hard chewable solids (e.g. cookies, crackers) _____

_____

Chewy foods (e.g.) meats _____

15. When did feeding problems start? _____

16. Changes in feeding problems over time: _____

_____

17. How does your child currently receive nutrition (check all that apply)

Bottle (nipple type)		Sippy cup (suction or no suction)		Tube	
Open cup		Spoon		Fork	
Other:					

18. Does your child self feed? Yes _____No_____

19. Does your child eat foods that are (check all that apply)

Cold		Room temperature		Warm	
Hot					

20. Does your child eat foods that are (check all that apply)

Salty		Spicy		Sweet	
Sour		Bland			

21. Does your child have any difficulty with the following (check all that apply)

Choking		Coughing		Sucking	
Gagging		Difficulty with chewing		Vomiting	
Drooling		Teeth grinding		Hypersensitivity	
Food refusals		Known penetration		Known aspirations	
Please provide details					

22. Does your child exhibit any of these behaviors during mealtimes (check all that apply)

Crying		Turning away		Spitting	
Pushing spoon away		Overstuffing		Throwing food	
Holding food in mouth					
Please provide details					

23. Does your child follow a special diet (Ketogenic, casein/gluten-free, etc.)

Yes _____ No_____

If yes, which? _____

24. What are your child's preferred foods? _____

_____

25. How does your child indicate that he/she is hungry? _____

_____

26. How does your child indicate when he/she is full? _____
_____

27. How does the meal usually take? _____

28. Does your child show signs of becoming tired as the meal progresses?
Yes _____No_____
29. Can your child keep his/her head up during the meal? Yes _____No _____

30. With whom does the child eat? _____

31. Where and what kind of seating is used for feeding time? _____

_____

32. What strategies have been used to help at mealtimes? (I.e. Bribing, coercion, time out)

_____

33. What behavior did these strategies help with? _____

_____

Feeding History

1. Did you child breast feed _____bottle feed _____How long? _____
   If bottle fed, what formula was used? _____
   Were there any problems? _____
2. What age did you introduce your child to:

Strained foods (stage 1 & 2)		Did they eat a full range of foods of this texture?	
Junior baby foods (stage 3)		Did they eat a full range of foods of this texture?	
Finely chopped foods, toddler		Did they eat a full range of foods of this texture?	
Regular table foods		Did they eat a full range of foods of this texture?	

3. Did your child have any difficulty transferring to different textures? Ex: liquid to puree or thick liquids to mixed and solids? Yes _____No_____
Describe._____

4. Please list any other concerns you have about feeding. _____
   _____

If you have any questions or concerns before your evaluation date please contact:

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