



Adults To Pediatrics Therapy, LLC

Rehabilitation Services

CASE HISTORY FORM FOR INFANTS WITH FEEDING PROBLEMS (0-4 MONTHS)

IDENTIFYING AND FAMILY INFORMATION

Child's Name: _____ Date of Birth: _____ Sex: Male Female

Mother's Name: _____ Address: _____

Daytime Phone: _____ Home: _____ Cell: _____

E-Mail: _____

Father's Name: _____ Address: _____

Daytime Phone: _____ Home: _____ Cell: _____

E-Mail: _____

Doctor's Name: _____ Phone: _____ Fax: _____

Other physicians treating child: _____ Phone: _____

Why is your child being seen for a feeding evaluation? _____

MEDICAL HISTORY

Has your child had any surgeries? Yes No

If yes, please describe and include dates: _____

Has your child ever been hospitalized? Yes No

If yes, list reason(s) and date(s): _____

Does your child have any allergies (food or otherwise)? Yes No

If yes, please list: _____

Is your child currently (or recently) under a physician's care? Yes No

If yes, why? _____

"Working together to communicate, one sound at a time."

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Please list any medications your child takes regularly: _____

BIRTH HISTORY

Was there anything unusual about the pregnancy or birth? Yes No

If yes, please describe: _____

How many months was the pregnancy? _____

Weight of your child at birth: _____

How many months was the pregnancy? _____

Were there any problems immediately after the birth? Yes No

If yes, please describe: _____

FEEDING HISTORY

Was your child breast-fed? Yes No

If yes, how long: _____

Were there any problems with breast-feeding (e.g. poor suck, slow to feed)? _____

When was your child first given a bottle? _____

Were there any problems with bottle-feeding (e.g. poor suck, slow to feed)? _____

How many times a day is your child fed? _____

How is your child positioned when eating (e.g., held by caregiver, swaddled in blanket, held facing caregiver)? _____

Does your child eat more/less when he/she is at daycare/baby-sitter/grandparents/other?

Please Describe: _____



Does your child receive supplemental (tube) feeding?

Yes

No

If yes, please provide the following information:

Amount: _____ Rate: _____ NG: _____ PEG: _____ PEJ: _____

Bolus (given via syringe several times a day): _____

Continuous (connected to pump): _____

Approximately how much liquid does your child drink at each meal? _____

How long does each meal take? _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____