



Adults To Pediatrics Therapy, LLC

Rehabilitation Services

CASE HISTORY FORM FOR CHILDREN WITH FEEDING PROBLEMS (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: _____

DEVELOPMENTAL HISTORY

Please tell the approximate age your child achieved the following developmental milestones:

_____ sat alone	_____ walked
_____ crawled	_____ dressed him/herself
_____ stood alone	_____ toilet trained

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)? _____

When was your child weaned from breast and/or bottle? _____ Breast _____ Bottle

When did your child begin eating solid foods? _____

Were there any problems with this? _____

When did the child start to feed him/herself? _____

If your child does not feed him/herself, who feeds him/her? _____



Does your child drink juice?

Yes

No

If yes, how much in a day? _____

Is the juice given before, during, or after the meal? _____

Does your child exhibit any of the following behaviors?

- _____ crying _____ spitting food out of his/her mouth _____ holding food in his/her mouth
- _____ gagging _____ getting down from the table during the meal _____ regurgitating food
- _____ vomiting

How many times a day is your child fed? _____

How long does each meal take? _____

Where does your child eat? _____

Who else is present for your child's meals? _____

How is your child positioned when eating (e.g., sitting in high chair, sitting on the floor)?

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 are liquids presented?

- _____ Bottle _____ Breast
- _____ Type of Nipple _____ _____ Cup
- _____ Spout
- _____ Lid with no spout
- _____ Cut-out cup

Approximately how much food does your child eat at each meal? _____

What consistency of foods does your child eat?

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



- | | |
|--|--|
| <input type="checkbox"/> regular liquids | <input type="checkbox"/> Stage 1 baby food (smooth) |
| <input type="checkbox"/> thickened liquids | <input type="checkbox"/> Stage 2 baby food (semi-chunky) |
| <input type="checkbox"/> baby cereal | <input type="checkbox"/> Stage 3 baby food (chunky) |
| <input type="checkbox"/> mashed table food | <input type="checkbox"/> regular table food |

What are some of your child's favorite foods? _____

If different from favorite foods, what are some easy foods for your child to eat? _____

What foods will your child not eat? _____

If different from foods your child will not eat, what are some difficult foods for your child to eat?

What do you do when your child does not eat appropriately? _____

List some good things that your child does at mealtime (e.g., sits at table, eats certain foods): _____

List some things you think your child should be doing at mealtime that he/she does not do (e.g., eating different kinds of foods): _____

List some things you think your child should not be doing at meals (e.g., having a tantrum, throwing food) _____

What have you tried to do to help your child with his/her feeding problem? _____

Please describe any other feeding problem(s) that your child is experiencing: _____



Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____