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? _____

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
_____ crawled
_____ stood alone
_____ walked
_____ dressed him/herself
_____ 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
Type of Nipple_____

____ Breast
____ 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?

_____ regular liquids
_____ thickened liquids
_____ baby cereal
_____ mashed table food
_____ Stage 1 baby food (smooth)
_____ Stage 2 baby food (semi-chunky)
_____ Stage 3 baby food (chunky)
_____ 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 kids 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: _____