

Adults To Pediatrics Therapy, LLC

Rehabilitation Services

CASE HISTORY FORM FOR CHILDREN WITH FEEDING PROBLEMS (4 MONTHS+)

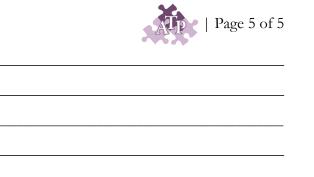
| IDENTIFYING AND FAMILY I | NFORMATION | | |
|---|-------------------------------|------|------|
| Child's Name: | Date of Birth: | Sex: | ale |
| | Address: | | |
| | Home: | | |
| E-Mail: | | | |
| Father's Name: | Address: | | |
| | Home: | | |
| E-Mail: | | | |
| Doctor's Name: Other physicians 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 in | nclude dates: | | |
| Has your child ever been hospita | alized? | Yes | □No |
| If yes, list reason(s) and date | e(s): | | |
| Does your child have any allergie If yes, please list: | es (food or otherwise)? | Yes | □ No |
| Is your child currently (or recent | ly) under a physician's care? | Yes | ☐ No |

| 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 HISTOR | Y | |
| Please tell the approximate age your child achieved the following de | evelopmental milesto | nes: |
| | walked dressed him/hers toilet trained | self |
| 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 mou gagging getting down from the table duri vomiting | | | his/her mouth od |
| 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 | g in high chair, sittin | g on the floor) | • |
| | | | |
| Please Describe: | | | |
| Does your child receive supplemental (tube) feeding? | | Yes | ☐ No |
| If yes, please provide the following information: | | | |
| Amount: Rate: NG: | PEG: | P | EJ: |
| 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 | | _ | |
| | Spout Lid w | ith no spout | |
| | Cut-o | | |
| Approximately how much food does your child eat at e | each meal? | | |

What consistency of foods does your child eat?

| - | thickened liquids baby cereal | 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 favori | te foods, what are some ea | sy foods for your child to eat? |
| What foods will your cl | hild not eat? | |
| If different from foods | your child will not eat, wh | at are some difficult foods for your child to eat? |
| | | |
| What do you do when | your child does not eat app | propriately? |
| List some good things | that your child does at me | ealtime (e.g., sits at table, eats certain foods): |
| _ • | • | doing at mealtime that he/she does not do (e.g., eating |
| food) | | be doing at meals (e.g., having a tantrum, throwing |
| What have you tried to | do to help your child with | his/her feeding problem? |
| Please describe any otl | her feeding problem(s) tha | at your child is experiencing: |
| | | |
| | | |
| | | |
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| | | |



| Parent/Guardian Name: _ | | | |
|-------------------------|--|--|--|
| , | | | |