Blank Children's Hospital
UnityPoint Health

FEEDING THERAPY CASE HISTORY

Please complete this form before your child's Feeding Evaluation

Nutrition and Feeding

1. Current Weight: _____ Height: _____ (as of:) _____
2. Does you child have difficulty gaining weight? ☐ Yes ☐ No
3. Have there been any past or present nutritional concerns? ☐ Yes ☐ No
4. What help have you had in managing nutrition? (i.e., nutritional consultations, provider's, suggestions, special formulas, foods, etc.): _____

_____

5. Did you have any concerns related to your child's feeding as an infant, if so please explain: _____

_____

6. Does or has your child have/had (check all that apply):
   - ☐ G-tube or J-tube: Start: _____ Stop: _____
   - ☐ Nasogastric Tube: Start: _____ Stop: _____
   - ☐ Oral-Gastric Tube: Start: _____ Stop: _____

   Why were the tubes placed? _____
   How many feedings per day does your child receive? _____ ☐ Bolus ☐ Continuous
   Type of formula? _____
7. What type of formula/milk do you use for oral feedings? _____
8. Check all that apply (currently or in the past):
   - Breast: ☐ Yes ☐ No How often? _____ How long on each breast? _____
     Age started: _____ Age stopped: _____
   - Bottle: ☐ Yes ☐ No How often? _____ How many ounces per feeding? _____
     Age started: _____ Age stopped: _____
     Length of time to take bottle? _____ Nipple used: _____
   - Cup: ☐ Yes ☐ No How often? _____ How many ounces per feeding? _____

   Does your child know how to use a straw? ☐ Yes ☐ No
   Do you need to assist with cup drinking? ☐ Yes ☐ No
   Does your child know how to use utensils? ☐ Yes ☐ No
9. Please list food your child particularly likes, or are easy for him/her to handle: _____

_____

10. Please list foods your child particularly dislikes, or can not eat well. Describe why they are difficult for your child: _____

_____

_____

11. Please list child's normal bowel pattern: _____ times/day
    Chronic Constipation? ☐ Yes ☐ No Chronic diarrhea? ☐ Yes ☐ No Blood in stool? ☐ Yes ☐ No
12. Is your child vomiting? ☐ Yes ☐ No If yes, how frequently, times of day, with feedings, after feedings, etc.:

_____

_____

13. List any family medical history of feeding or GI disorders, including any parent/sibling eating disorders or peculiarities:

_____

_____

_____

Patient Label

14. Has your child had any of the following tests? (please select)

☐ Upper GI ☐ Swallow Study ☐ Endoscopy ☐ Nuclear Med/Gastric Emptying ☐ pH Probe

Results: _____

15. Has your child had? (check all that apply)

☐ Frequent colds ☐ Bronchitis ☐ Asthma ☐ Bronchiomalacia ☐ Tracheomalacia

☐ Laryngomalacia ☐ Bronchopulmonary Dysplasia ☐ Use of Oxygen

☐ Tracheostomy (if yes, date placed: _____ date removed: _____)

Reason for tracheostomy: _____

Home health care services: ☐ Yes ☐ No If yes, what are they, and for how many hours?: _____

_____

Oral Motor Status

Do you notice any of the following:

a. Drooling	☐ Yes	☐ No
b. Continuous sucking; poor sucking	☐ Yes	☐ No
c. Biting – can the child bite off pieces of food voluntarily?	☐ Yes	☐ No
d. Poor tongue control (e.g., tongue thrust, poor motility)	☐ Yes	☐ No
e. Swallowing – does the child choke or gag often?	☐ Yes	☐ No
f. Lip control – can the child keep his/her mouth closed?	☐ Yes	☐ No
g. Chewing (for children over 12 mos.)	☐ Yes	☐ No
h. Hypersensitivity to food textures	☐ Yes	☐ No
i. Hypersensitivity to food temperature	☐ Yes	☐ No
j. Hypersensitivity to spoon	☐ Yes	☐ No

Positions, Equipment, and Environment for Feeding

1. What position do you typically use for feeding your child? (select all that apply):

☐ Sitting on your lap ☐ Reclined in your arms ☐ High Chair ☐ Booster Seat ☐ Adapted Chair

☐ Other: _____

2. Does your child eat alone or with the family? _____

3. Does your child have behavior problems during mealtimes? ☐ Yes ☐ No

If yes, please specify:

☐ throws food ☐ messy eater

☐ spits food ☐ takes food from others

☐ cries, screams ☐ refuses food

☐ leaves the table before finished ☐ overeats

☐ only eats certain foods ☐ other (please specify): _____

4. Are there any adaptations used to help your child maintain a correct sitting position? (select all that apply):

☐ Bolster ☐ Seat insert ☐ Chest strap ☐ Lap tray ☐ Head support ☐ Hip strap

☐ Other: _____

5. Does your child use any of the following (select all that apply):

☐ Latex covered spoon ☐ Spoon ☐ Knife ☐ Fork ☐ Special nipple ☐ Training cup ☐ Cut out cup

☐ Other: _____

6. Do you let your child get messy with foods while they are eating? ☐ Yes ☐ No

If yes, does your child enjoy this or fuss with being messy? ☐ Enjoy ☐ Fuss

Comments: _____

Do you, as the parent, have trouble letting your child get messy with foods? ☐ Yes ☐ No

Patient Label

7. Do you have any problems brushing your child's teeth? ☐ Yes ☐ No
   If yes, please describe: _____
   If your child is over 3 years, have they been to the dentist? ☐ Yes ☐ No
8. Does your child show any negative response to his/her face being touched or washed? ☐ Yes ☐ No
   If yes, please describe: _____
9. How would you describe your child's personality? _____

_____

10. Does your child bring toys or hands to his/her mouth? ☐ Yes ☐ No
11. Does your child suck on his/her pacifier? ☐ Yes ☐ No
12. Does your child feed him/herself? ☐ Yes ☐ No
13. Does your child like to be (select all that apply): ☐ Touched ☐ Cuddled ☐ Rocked ☐ Swung
14. Do you have any concerns with your child's sleeping pattern? ☐ Yes ☐ No
    Please describe: _____
15. Does your child fall asleep on his/her own? ☐ Yes ☐ No

Feeding Practices

1. At what age were solids introduced? _____
2. Does your child still use a bottle and/or pacifier? _____
3. Food consistency (please select all that apply):

Food consistency				
Liquids/soups	☐ Don't eat	☐ Can eat	☐ Never tried	☐ Can't eat
Stage 1 or 2 baby foods	☐ Don't eat	☐ Can eat	☐ Never tried	☐ Can't eat
Stage 3/junior baby foods	☐ Don't eat	☐ Can eat	☐ Never tried	☐ Can't eat
Creamy foods	☐ Don't eat	☐ Can eat	☐ Never tried	☐ Can't eat
Blenderized table food	☐ Don't eat	☐ Can eat	☐ Never tried	☐ Can't eat
Mashed table food	☐ Don't eat	☐ Can eat	☐ Never tried	☐ Can't eat
Chopped table food	☐ Don't eat	☐ Can eat	☐ Never tried	☐ Can't eat
Regular table food	☐ Don't eat	☐ Can eat	☐ Never tried	☐ Can't eat
Crisp food (crackers)	☐ Don't eat	☐ Can eat	☐ Never tried	☐ Can't eat
Chewy food (meat)	☐ Don't eat	☐ Can eat	☐ Never tried	☐ Can't eat
Crunchy food (carrot)	☐ Don't eat	☐ Can eat	☐ Never tried	☐ Can't eat

Note reason for refusal of foods: _____

_____

Describe any special diet: _____

_____

Meal Pattern

1. Do the child's food habits and preferences match the family's? ☐ Yes ☐ No
2. Does the child eat little at meals and snack throughout the day? ☐ Yes ☐ No
3. How long does it take for the child to complete a meal? (check one):
   ☐ Less than 10 minutes ☐ 10-20 minutes ☐ 20-30 minutes ☐ 30-60 minutes ☐ over 60 minutes
4. How does the child indicate hunger? _____

_____

Patient Label