



VIDEOSWALLOW CASE HISTORY

Please complete this form before your child's videoswallow.

Date: _____
Child's Name: _____ DOB: _____ Sex: M F
Person Completing Questionnaire: _____
Relationship to child: _____ Phone: _____

Prenatal and Birth History:

During this pregnancy, did the child's mother experience any unusual illness, condition or accident: Yes No
If yes, please provide information: _____
Was there drug/alcohol use during pregnancy? Yes No If yes, please describe: _____
Length of Pregnancy: _____ Type of Delivery: Cesarean Vaginal
Child's Birth Weight: _____ Hospital Stay following birth: _____
Was infant in the Intensive Care Nursery? Yes No For how long? _____
Were any of the following present after birth?
Seizure Activity: Yes No Difficulty regaining birth weight: Yes No
Difficulty sucking/swallowing: Yes No Need for oxygen: Yes No

Medical Information:

Primary Physician/Practitioner: _____ Phone: _____
Referring Physician: _____ Phone: _____
Medical Diagnosis: _____
List Reason for Referral: _____

Has your child had any of the following tests?

Upper GI: Swallow Study: Endoscopy:
When/Where: _____ When/Where: _____ When/Where: _____
Results: _____ Results: _____ Results: _____

Nuclear Med/Gastric Emptying: pH Probe:
When/Where: _____ When/Where: _____
Results: _____ Results: _____

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: _____)

Therapeutic History:

Does your child receive: Occupational Therapy Physical Therapy Speech Therapy
Where: _____ How often: _____
Therapist(s): _____

*Release of Information will need to be signed to provide information from this video to these individuals.

Patient Label

Nutrition and Feeding:

- Does your child have difficulty gaining weight? Yes No
- Have there been any past or present nutritional concerns? Yes No
- 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? _____
- Is your child drinking from (check all that apply):
 - Breast: Yes No How often? _____ How long on each breast? _____
 - Bottle: Yes No How often? _____ How many ounces per feeding? _____
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
- Please list food your child particularly likes or that is easy for him/her to handle: _____
- Please list foods your child particularly dislikes or cannot eat well. Describe why they are difficult for your child:

Positions and Equipment for Feeding:

- What position do you typically use for feeding your child? (check all that apply):
 - Sitting on your lap Reclined in your arms High Chair Booster Seat Adapted Chair
 - Other: _____
- Are there any adaptations used to help your child maintain a correct sitting position? Yes No (check all that apply)
 - Bolster Seat insert Chest strap Lap tray Head support Hip strap
 - Other: _____
- Can your child do any of the following? (check all that apply):
 - Hold head up alone? Yes No Since age: _____
 - Roll? Yes No Since age: _____
 - Crawl? Yes No Since age: _____
 - Sit alone? Yes No Since age: _____
- 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
Do you, as the parent, have trouble letting your child get messy with foods? Yes No
- Does your child suck on his/her pacifier? Yes No
- Does your child feed him/herself? Yes No
- On a scale of 1 to 10 (1 being the least stressed and 10 being the most stressed), how would you rate your level of stress in relationship to your child's feeding? (please check the appropriate number):

(Least stressed) 1 2 3 4 5 6 7 8 9 10 (Most stressed)

*Thank you for your time and input. Please remember to return in the enclosed envelope, fax to 515-241-8696, or bring with you. We look forward to meeting your child and you.

Patient Label