SPAULDING™
EILEEN M. WARD
OUTPATIENT CENTER
*for Children*
SANDWICH

PATIENT IDENTIFICATION AREA

**CASE HISTORY/INTERVIEW FORM FOR CHILDREN WITH FEEDING PROBLEMS (0 - 4 months of age)**


**NAME:**_____ **AGE:**_____ **DOB:**_____

**Medical Diagnosis:** _____

**Primary Care Physician:** _____

**Other physicians treating your child:** _____

_____

_____

**Why is your child being seen for a feeding evaluation?:** _____

_____

**MEDICAL HISTORY:**

**Does your child have any allergies (food or otherwise)?** ☐ No ☐ Yes If Yes, please list:

_____

☐ Colic: _____ ☐ Reflux _____ ☐ Constipation _____

**Has your child had any surgeries?** ☐ No ☐ Yes If Yes, please list when, where and dates:

_____

_____

**List other medical issues**: _____

_____

**BIRTH HISTORY:**

**Pre-term issues?** ☐ No ☐ Yes Describe: _____

_____

**How many weeks gestation?** _____ **Birth weight?** _____

**Describe delivery:** ☐ Vaginal ☐ C-section

**Were there problems immediately after birth?** ☐ No ☐ Yes Describe:_____

_____

**How long was the baby in the hospital?**_____

**Are your child's immunizations up to date?** ☐ No ☐ Yes

Primary Care Physician where immunizations are on record:

Name: _____ Phone Number: _____

**CASE HISTORY/INTERVIEW FORM FOR CHILDREN WITH FEEDING PROBLEMS (0 - 4 months)**

**CASE HISTORY/INTERVIEW FORM FOR CHILDREN WITH FEEDING PROBLEMS (0 - 4 months of age)**


**CASE HISTORY/INTERVIEW FORM FOR CHILDREN WITH FEEDING PROBLEMS (0 - 4 months)**

**FEEDING HISTORY:**

**When did he/she begin eating?** _____

**Was your child breast fed?** ☐ No ☐ Yes If Yes, how long? _____

**Were there any problems with this (e.g., poor suck, slow to feed)?** _____

_____

**Has your child been bottle fed?** ☐ No ☐ Yes

**Were there any problems with this (e.g., poor suck, slow to feed)?** _____

_____

**What brand of bottle?** _____

**What type of nipple?** _____

**What kind of formula?** _____

**How often does your baby eat?** _____

**Has your child experienced spoon feeding?** ☐ No ☐ Yes When? _____

Describe: _____

**How often is your child fed?** _____

**How is your child positioned? (e.g., held by caregiver, swaddled in a blanket, held facing away from or toward a caregiver):** _____

_____

**Has your child ever received supplemental feedings via a tube?** ☐ No ☐ Yes

| **If Yes, what kind?** | **Date:** |
|---|---|
| ☐ (NG) Nasogastric | _____ |
| ☐ (PEG) Gastrostomy | _____ |
| ☐ (PEJ) Gastrojejunostomy | _____ |
| ☐ (TPN) Total or temporary parental nutrition | _____ |

Amount: _____ Rate: _____

Bolus (given via syringe several times a day): _____

Continuous (connected to pump): _____

**How much liquid does your child consume at each feeding?:** _____

Does he/she have: ☐ Colic ☐ Reflex ☐ Constipation ☐ Food allergies

Describe: _____

_____

**How long does each feeding take?** _____

**CASE HISTORY/INTERVIEW FORM FOR CHILDREN WITH FEEDING PROBLEMS (0 - 4 months of age)**


**Pain 0 - 10:** (0 - no pain, 10 = unbearable pain) Pain at best _____, at worst _____.

**Do you or others who spend time with your child (daycare, grandparent, etc.) have any concerns about the following:**

- ☐ Hearing
- ☐ Difficulty changing activities
- ☐ Easily upset
- ☐ Easily distracted
- ☐ Vision
- ☐ High activity level
- ☐ Difficulty calming down when upset
- ☐ Irritable or cranky

**If yes to any of the above, please describe:**_____

_____

**Screening for Abuse and Neglect:**

Do you suspect your child has been physically, sexually, or emotionally abused? ☐ No ☐ Yes

May we audio tape your child's feeding/swallowing evaluation if needed? ☐ No ☐ Yes

May we videotape the evaluation and/or treatment sessions if needed? ☐ No ☐ Yes

*****Please attach any other information or comments that might be helpful along with any** reports/notes regarding your child's testing and/or previous therapy.***

Please sign below to confirm that:

a) The above information is accurate to the best of your knowledge.
b) You have been given a copy of the policies of Spaulding Rehabilitation Hospital – Cape Cod Outpatient Program (available at registration).
c) You agree to notify this facility with any changes to your child's status as a patient at Spaulding Rehabilitation Hospital – Cape Cod Outpatient Program.

**Person completing form:** _____

| _____ | _____ | _____ |
|---|---|---|
| **Caregiver Signature** | **Date** | **Time** |
| _____ | _____ | _____ |
| **Therapist Signature** | **Date** | **Time** |

**CASE HISTORY/INTERVIEW FORM FOR CHILDREN WITH FEEDING PROBLEMS (0 - 4 months)**