SPAULDING
EILEEN M. WARD
OUTPATIENT CENTER
for Children
SANDWICH

PATIENT IDENTIFICATION AREA

CASE HISTORY/INTERVIEW FORM FOR CHILDREN WITH FEEDING PROBLEMS (4 months and older)

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

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

_____

MEDICAL HISTORY:

Has your child had any surgeries? ☐ No ☐ Yes If Yes, please list with dates:_____

_____

Has your child ever been hospitalized? ☐ No ☐ Yes If Yes, please list reason(s) and dates(s):

_____

_____

Is your child on any medication? ☐ No ☐ Yes If Yes, please list: _____

_____

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

_____

Does your child take vitamins? ☐ No ☐ Yes What kind? _____

BIRTH HISTORY:

Weight of your child at birth:_____

Was your child full-term? ☐ No ☐ Yes If No, how many weeks gestation? _____

Were there any problems during pregnancy? ☐ No ☐ Yes If Yes, please describe: _____

_____

_____

Were there any problems immediately after birth? ☐ No ☐ Yes If Yes, please describe: _____

_____

_____

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

Primary Care Physician where immunizations are on record:

Name: _____ Phone Number: _____

How much does your child weigh?_____

DEVELOPMENTAL HISTORY: (Please indicate ages)

Sitting unsupported_____ Walking_____

Crawling _____ Self-dressing: _____

Standing alone _____ Bladder & bowel control _____

Babble_____ First words _____

Bottle_____ Stopped drooling _____

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FEEDING HISTORY:

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

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

_____

When was your child first given a bottle? _____ Were there any problems with this (e.g., poor suck, slow to feed)? _____

_____

When did your child start to eat solid foods? _____

Were there any problems with this? _____

When was your child weaned from bottle/breast? _____

When did the child start to feed him/herself? _____

Does the child drink juice? ☐ No ☐ Yes If Yes, how much a day? _____

Is the juice given before, during, after a meal? (Please circle)

Does your child exhibit any of the following behaviors:

☐ Crying	☐ Vomiting	☐ Coughing
☐ Gagging	☐ Choking	☐ Refusing to eat
☐ Getting down from the table during meal	☐ Holding food in his/her mouth	☐ Spitting food out of his/her mouth
	☐ Regurgitating food	

How many times a day does your child eat? _____

If your child does not feed him/herself, who feeds him/her? _____

Where does your child eat? _____

How is your child positioned when eating (e.g., sitting in high chair, sitting on the floor)? _____

_____

Who else is present for meals? _____

Does your child eat more / less, same / different foods when he/she is at daycare / baby-sitter / grandparents / other? (Please circle and describe _____

_____

Does your child receive supplemental (tube) feeding? ☐ No ☐ Yes

If Yes, Amount _____ NG: _____ TPN: _____

Rate _____ PEG: _____ PN: _____

PEJ: _____

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

Continuous (connected to pump): _____

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What consistency of foods does your child eat?

- ☐ Regular liquids
- ☐ Thickened liquids
- ☐ Baby cereal
- ☐ Stage 1 baby foods (smooth)
- ☐ Stage 2 baby foods (semi-chunky)
- ☐ Stage 3 baby foods (chunky)
- ☐ Mashed table food
- ☐ Regular table food

How is liquid presented?

- ☐ Bottle _____
  Type of nipple _____
- ☐ Breast
- ☐ Cup
  - ☐ Spout
  - ☐ Lid with no spout
  - ☐ Cut-out cup

Approximately how much liquid does your child drink at each meal? _____

Approximately how much food does your child eat at each meal? _____

How long does each meal take? _____

What do you do when your child does not eat appropriately? _____

_____

What are some of your child's favorite foods? _____

_____

If different from favorite foods, what are some easy foods for your child to eat? _____

_____

Which foods will your child not eat? _____

_____

My child is in

- ☐ Daycare (name) _____
- ☐ Early Intervention (name) _____
- ☐ Pre-school (name) _____
- ☐ Head Start (name) _____
- ☐ Regular/typical class, specify grade level _____
- ☐ Regular/typical class with special education resource, grade level _____
- ☐ Full time special education _____
- ☐ Other (specify) _____

Does your child receive any of the following services:

Service	Yes	No	Where	How often?
Speech Therapy				
Occupational Therapy				
Physical Therapy				
Counseling/Behavior Therapy				
Visiting Nurses				
Nutrition				
Other				

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

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

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

_____

GASTROINTESTINAL:

How often does your child have a bowel movement? _____

Does your child have problems with the following: ☐ Diarrhea ☐ Constipation ☐ Vomiting

If yes, please describe: _____

_____

_____

Has he/she been treated for growth problems? ☐ No ☐ Yes

If yes, please describe: _____

_____

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

EATING ENVIRONMENT:

Where does your child usually sit during mealtimes?

- ☐ Infant seat
- ☐ Chair at table
- ☐ Child stands
- ☐ Child wanders around
- ☐ On caretakers lap
- ☐ In front of TV
- ☐ Highchair
- ☐ Held in arms
- ☐ Booster seat
- ☐ Other _____

In what location of the house is your child fed?

☐ Kitchen ☐ Dining room ☐ Living Room ☐ Walking around

☐ Other _____

At what other locations does your child eat/drink?

☐ Daycare ☐ School ☐ Other relative's/friend's home ☐ In the car

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Where and with whom does your child eat the best? _____

_____

CURRENT FEEDING / DRINKING SKILLS:

Who feeds your child? (check all that apply) ☐ Mother ☐ Father ☐ Sibling ☐ Teacher
☐ Grandparent ☐ Daycare provider ☐ Other (please specify) _____

Please tell us about your child's current feeding skills:

a. Finger feeding? ☐ No ☐ Yes
If yes, how well? ☐ Beginning ☐ Partially successful ☐ Completely successful
b. Uses a spoon and/or fork? ☐ No ☐ Yes
If yes, how well? ☐ Beginning ☐ Partially successful ☐ Completely successful
c. Breast-feeding? ☐ No ☐ Yes
If yes, how well? _____

If different from foods that your child will not eat, what are some foods for your child to eat?

_____

_____

List some good things that your child does at meal times (e.g., sits at the table, eats certain foods):

_____

_____

List some things that you think your child should be doing at meal times that he/she does not do (e.g., eating different kinds of foods): _____

_____

List some things that you think your child should not be doing at meal times (e.g., having a tantrum, throwing food): _____

_____

Does your child participate in tooth brushing? ☐ No ☐ Yes

Describe your tooth brushing routine: _____

_____

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: _____

_____

_____

_____

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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**

_____ _____
Therapist Signature **Date / Time**