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 your child have difficulty gaining weight? Yes or No
3. Have there been any past or present nutritional concerns? Yes or 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 or 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 or No How often? _____ How long on each breast? _____
     Age started: _____ Age stopped: _____
   - Bottle: Yes or No How often? _____ How many ounces per feeding? _____
     Age started: _____ Age stopped: _____
     Length of time to take bottle? _____ Nipple used: _____
   - Cup: Yes or No How often? _____ How many ounces per feeding? _____
   - Does your child know how to use a straw? Yes or No
   - Do you need to assist with cup drinking? Yes or No
   - Does your child know how to use utensils? Yes or 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 or No Chronic diarrhea? Yes or No Blood in stool? Yes or No
12. Is your child vomiting? Yes or 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:

_____

_____

_____

14. Has your child had any of the following tests? (Please circle)
    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 or No (If yes, what are they, and for how many hours?):

Oral Motor Status

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

Positions, Equipment, and Environment for Feeding

1. What position do you typically use for feeding your child? (circle 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 or No
   If yes, please specify:
   a. throws food _____ f. messy eater _____
   b. spits food _____ g. takes food from others _____
   c. cries, screams _____ h. refuses food _____
   d. leaves the table before finished _____ i. overeats _____
   e. only eats certain foods _____ j. other (please specify): _____
4. Are there any adaptations used to help your child maintain a correct sitting position? Yes or No
   (Circle all that apply): bolster seat insert chest strap lap tray head support hip strap
   Other: _____
5. Does your child use any of the following (circle 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 or 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 or No
7. Do you have any problems brushing your child's teeth? Yes or No
   If yes, please describe: _____
   If your child is over 3 years, have they been to the dentist? Yes or No
8. Does your child show any negative response to his/her face being touched or washed? Yes or No
   If yes, please describe: _____
9. How would you describe your child's personality? _____

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

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

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 or No
2. Does the child eat little at meals and snack throughout the day? Yes or 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? _____