Kids Abilities Pediatric Therapy

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PEDIATRIC FEEDING HISTORY FORM

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

1. Please explain, in your own words, what your child's current feeding problem is:

_____

_____

2. Was your child breast fed? From when to when: _____

   Was your child bottle fed? From when to when _____
   Please describe your child's initial skill on the breast and/or bottle:

_____

_____

3. During these early feedings, did your child frequently arch, cry, spit up, gag, cough, vomit or pull off the nipple? Circle the behaviors shown and describe when they would happen, why, for how long:

_____

_____

4. Describe how the weaning process off the breast and/or bottle went and why the child was weaned:

_____

_____

5. At what age did your child transition to Baby cereal? _____ Baby food? _____

   Finger foods? _____ Transition fully to table food? _____

Please describe how these transitions were handled by your child, especially if any difficulties happened:

_____

_____

_____

_____

IF YOUR CHILD EATS BY MOUTH, PLEASE ANSWER THE FOLLOWING QUESTIONS:

6a. List the foods that your child currently will eat and drink (put a star next to their favorites):

6b. List the foods your child refuses:

6c. List the foods your child is allergic to:

6d. Describe your child's mealtime:

Who typically feeds your child?

Who typically eats with your child?

What type of chair is used?

How long are meals typically?

Does your child use utensils or any type of special cups/bowls (describe)?

Are there any other activities going on at meals? What activities (describe)?

6e. What times does your child typically eat and what type (bottle, breast, solids)?

IF YOUR CHILD IS TUBE FED, PLEASE ANSWER THE FOLLOWING QUESTIONS:

7a. What type of formula is used and how do you mix it?

7b. Please detail your child's feeding schedule below.

Time of feeding (Start time)	NG, G or Continuous	Amount	Gravity or Pump	Over what time period or what rate

7c. Describe where your child is tube fed and what activities are occurring at the same time:

_____

7d. Describe your child's reactions to the tube feedings (connecting, during, disconnecting):

_____

***PLEASE ANSWER FOR ALL CHILDREN**

8. Has your child ever been on any type of special diet other than what you just described?

Yes ☐ No ☐

If yes, please describe type of diet, at what ages, why and what your child's response was:

_____

9. How do you know your child is hungry or full? _____

_____

10. Has your child lost or gained any weight in the last 6 months, and how much? _____

_____

11. Would you describe your child's weight as (check one): Ideal ☐ Underweight ☐ Overweight ☐

12. Does your child have/had any of the following problems? Please describe:

Dental ☐ Frequent constipation ☐ Frequent diarrhea ☐ Vomiting ☐

Choking ☐ Gagging ☐ Coughing ☐

13. Does your child take a vitamin supplement? Yes ☐ No ☐

If yes- which one? _____

14. Describe how you and your child feel after a feeding:

You: _____

Your child: _____

15. What other evaluations have been completed regarding your child's feeding difficulties and what were the results/what were you told?

16. What treatments have been tried for this problem, and what were the results?

17. How can we be most helpful to you and your child?