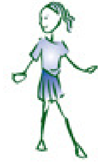
INTEGRATED CHILDREN'S THERAPIES

where children make connections



FEEDING HISTORY FORM

CHILD'S NAME: ______________________________________ **DATE OF BIRTH:** _______________________

Person Completing History: ☐Mother ☐ Father ☐ Self ☐ Other (specify) ____________________________

Child's Physicians and other Professionals:

PCP: __________________________ Address: ___________________________ Phone: ___________________

GI: ____________________________ Address: ___________________________ Phone: ___________________

Nutritionist: _____________________ Address: ___________________________ Phone: ___________________

Other: __________________________ Profession: _________________________ Phone: ___________________

General Information:

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

2. Was your child breast fed? ☐ YES ☐ NO from when to when? _______________________________________

   Was your child bottle fed? ☐ YES ☐ NO 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? Check 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:

72 Jefferson St., suite 202, Marlborough, MA 01752 • P: 508.485.5650 • F: 508.485.5423

<u>IF YOUR CHILD EATS BY MOUTH, PLEASE ANSWER THE FOLLOWING QUESTIONS</u>:

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 any foods that your child ate but will not longer eat:

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

6d. <u>Describe your child's mealtime</u>:
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 was your child's response:

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: ☐ Ideal ☐Underweight ☐ Overweight

12. Does your child have/had any of the following problems? ☐dental, ☐frequent constipation, ☐frequent diarrhea, ☐vomiting, ☐choking, ☐gagging, ☐coughing. Please describe:

13. Does your child take a vitamin supplement? ☐ YES ☐ NO 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?

Child's Physician and other Professionals:

Physician: ____________________ Address: ________________________ Phone: _________________

Other: _______________________ Profession: ______________________ Phone: _________________

Other: _______________________ Profession: ______________________ Phone: _________________

Other: _______________________ Profession: ______________________ Phone: _________________