



Child Case History Form Feeding/Swallowing

Name _____ Date _____

Date-of-Birth _____ Age _____

School _____ Grade _____

Native Language _____ Primary Language _____

Mother's Name _____ Father's Name _____

Address _____ Address (if different) _____

Phone _____ Phone _____

Home Work Cell (CIRCLE ONE)

Home Work Cell (CIRCLE ONE)

Alternate Phone _____ Alternate Phone _____

Home Work Cell (CIRCLE ONE)

Home Work Cell (CIRCLE ONE)

Email Address _____ Email Address _____

Person Completing Form _____

Physician's Name _____ Phone _____

Referred by _____

Please answer the following questions as thoroughly as possible

1. Birth weight _____

2. Birth complications _____

3. Diagnosis _____

4. Primary caregiver(s) _____

5. Other children in the home _____

6. Does your child have: Allergies? _____ Asthma? _____

Other medical complications? _____

FEEDING HISTORY

7. In infancy, child was _____ (breast fed, bottle fed, tube fed). If tube fed, why and for how long?

8. Was he/she on a ventilator? _____ If yes, how long? _____

9. How long did early feedings last? _____

10. Were any strategies (i.e., positioning, external jaw/cheek support, different bottles, nipples, etc.) used to help with early feeding?

If so, please explain _____

If your child is fed orally,

11. When did he/she transition from formula/breast milk/Pediasure, etc. to baby foods (pureed)? _____
12. When did he/she transition to textured foods? _____
13. When did he/she transition to soft solids? _____
14. When did he/she transition to solid foods? _____
15. What is his/her current diet? (Please provide amounts and types of a typical day's intake-both orally and by tube)
- _____
- _____

16. Check the following descriptions of behaviors/actions that are consistently exhibited (at least once per week) at the mealtime

- | | |
|--|---|
| <input type="checkbox"/> a poor appetite | <input type="checkbox"/> disinterest in food |
| <input type="checkbox"/> food refusal | <input type="checkbox"/> extreme food "pickiness" |
| <input type="checkbox"/> talks with mouth full | <input type="checkbox"/> gagging with or without |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> mealtime tantrums |
| <input type="checkbox"/> unusual food habits | <input type="checkbox"/> food-texture selectivity |
| <input type="checkbox"/> excessive overeating | <input type="checkbox"/> yells |
| <input type="checkbox"/> whining or fussing at | <input type="checkbox"/> mealtimes |
| <input type="checkbox"/> requests for non-served foods | <input type="checkbox"/> takes food from another's tray/plate |
| <input type="checkbox"/> gets out of seat | <input type="checkbox"/> easily distracted from eating |
| <input type="checkbox"/> throws food | <input type="checkbox"/> "messy" eating; frequent spills |
| <input type="checkbox"/> has ability, but doesn't use napkin | <input type="checkbox"/> prefers liquids over solid food |
| <input type="checkbox"/> poor eye contact with communication partner or feeder | <input type="checkbox"/> doesn't keep hands to self |
| <input type="checkbox"/> eats too fast | <input type="checkbox"/> eats too slow |
| <input type="checkbox"/> doesn't orient to feeder, but orients at other times | <input type="checkbox"/> expelling of food |
| <input type="checkbox"/> takes bites that are too large | <input type="checkbox"/> exhibits self-stimulatory behavior at mealtime |
| <input type="checkbox"/> talks too much at mealtime | <input type="checkbox"/> takes bites that are too small |
| <input type="checkbox"/> drinks too fast | <input type="checkbox"/> ignores communication partner/feeder |
| <input type="checkbox"/> chews with mouth open | |

17. Check the following reactions that have been observed with eating

- Coughing:
How often per week, month, etc.? _____
- Gagging:
How often per week, month, etc.? _____
- Slow eating:
How often per week, month, etc.? _____
- Choking:
How often per week, month, etc.? _____
- Wet vocal quality:
How often per week, month, etc.? _____
- Noisy breathing associated with feeding How often per week, month, etc.? _____
- Upper respiratory infections, pneumonias, etc How often in the past year? _____
- Other physical signs associated with eating (i.e., heart rate, color changes, respiratory changes, weight loss, etc):
Describe what has been observed and how often it has occurred in the past year _____
- _____
- Hospitalizations in the past year? Why? How long? _____

18. What is your child's current weight & height (if known)? _____

Feeding Preferences and Current Practices

19. What is your child's preferred temperature for liquids? _____
For foods traditionally served warm? _____
For foods traditionally served cold? _____
20. Does your child prefer foods:
With strong tastes? _____
With bland tastes? _____
Both? _____
21. Please list 4-5 of your child's favorite foods _____

22. Please list 4-5 foods your child doesn't like _____

23. Is your child's food modified for him/her (i.e., chopped, ground, pureed, etc.)? If so, please explain _____

24. Does your child receive any vitamin/mineral supplements? If so, please describe _____

25. Does your child use any particular bowls, utensils, cups, etc? If so, please describe _____

26. Does your child sit in a special chair for meals? _____ If so, please describe _____

27. Does your child "help" with self-feeding? _____
With utensils? _____
With fingers? _____
28. Does your child feed himself/herself? _____
29. Is your child fed by others nearly 100% of the time? _____

Communication

30. Is your child's primary mode of communication:
Verbal? _____
Facial expressions? _____
Vocalizations? _____
Points/gestures? _____
AAC devices? _____
Other? _____
31. What are your goals for your child related to feeding/swallowing? _____

32. What are your primary concerns for your child related to feeding/swallowing? _____
