


ECKELMANN-TAYLOR SPEECH AND HEARING CLINIC
Illinois State University

Child Case History Form Feeding/Swallowing

Name _____ Date _____

Date of Birth _____ Age _____ Pronouns _____

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 _____

Insurance:

Primary _____ Secondary _____

Policy # _____ Policy # _____

Group # _____ Group # _____

Subscriber Name _____ Subscriber Name _____

Subscriber Phone Number & Address _____

Subscriber DOB _____ Subscriber DOB _____

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 (e.g. 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

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

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? _____

_____