PEDIATRIC FEEDING/SWALLOWING HISTORY AND ASSESSMENT

Child’s Name: _______________________________  Today’s Date: _______________________________
Date of Birth: _______________________________  Person Completing This Form: ________________

1. What concerns do you have about your child’s eating that you would like to address this visit?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

A. GENERAL HISTORY

1. Does your child have any of the following symptoms when eating or drinking? (Check all that apply)
   - Gagging
   - Coughing
   - Choking
   - Vomiting
   - Eats a limited variety of food/selective
   - Slow weight gain
   - Refuses to eat
   - Limited volume/not eating enough
   - Difficulty swallowing
   - Refuses to swallow/holds food in mouth
   - Spits food out
   - Trouble chewing
   - Difficulty progressing to table food
   - Other (specify): ______________________________

2. At what age did your child’s eating become a concern? ________________________________

3. What strategies have you tried to deal with your child’s eating problems? (Check all that apply)
   - Distraction during meals (ipad, TV)
   - Skipping meals
   - Rewards
   - Feeding child only when they request
   - Coaxing
   - Other (specify): ______________________________
   - Forcing
   - Allowing child to drink more fluids
   - Giving preferred foods
   - Punishment
   - High calorie supplements/formula

4. Does your child have any physical pain while/associated with eating or drinking?  Yes  No
   If YES, please circle your child’s usual level of pain/discomfort with eating or drinking on the scale:
B. BIRTH HISTORY

1. Was your baby born within 2 weeks of his/her due date? Yes No
   If not, at how many weeks gestation was the baby born? __________

2. How much did your baby weigh at birth? __________
   Born by: vaginal caesarian section

3. Did you have any of the following problems with pregnancy, labor, or delivery:
   - Gestational diabetes
   - Preterm labor
   - Eclampsia/pre-eclampsia
   - Abnormal ultrasound
   - Infection
   - Other (specify): __________

4. Did your baby have any of the following problems in the nursery (hospital):
   - Gastroesophageal reflux (GER)
   - Apnea
   - Feeding and growth issues
   - Mechanical ventilation
   - Intraventricular hemorrhage (brain bleed)
   - CPAP therapy
   - Tube feedings
   - Bronchopulmonary dysplasia (BPD)
   - Necrotizing enterocolitis (NEC)
   - Other (specify): __________

5. How long was your baby hospitalized after birth? __________________________

C. MEDICAL HISTORY

1. Please check any of your child’s medical, developmental, and/or mental health diagnoses:
   - GE reflux
   - Esophagitis
   - Neurologic (brain) issues
   - Renal (kidney) issues
   - Autism/PDD
   - Failure to thrive/slow growth
   - Pulmonary (lung) issues (asthma)
   - Other (specify): __________
   - Developmental delay
   - Cardiac (heart) issues
   - Constipation
   - Diarrhea
   - Mental health (specify): __________
   - Genetic/chromosome abnormality (specify): __________
   - Slow stomach emptying
   - Toxin exposure in utero (drugs, alcohol)

2. How often does your child have a bowel movement?
   - Daily
   - Every other day
   - Other (specify): __________

3. Does your child have any allergies? Yes No
   - Food
   - Medication
   - Contact
   - Contrast dyes
   - Seasonal/environmental
   - Adhesives/tape
4. Does your child have any religious or cultural barriers pertaining to food?  Yes  No

D. PEDIATRIC CARE

1. Does your child currently see any specialists?  Yes  No

<table>
<thead>
<tr>
<th>Name of Specialist</th>
<th>Specialty</th>
<th>Location</th>
<th>Date last seen</th>
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2. Does your child see a dietician/nutritionist?  Yes  No

3. Have any of the following medical tests been done?

- Upper GI series
- Endoscopy
- Head CT scan
- Allergy testing
- Milk scan
- pH probe
- Head MRI scan
- Modified barium swallow study
- Genetic (chromosome) testing
- Neuropsychological testing
- Other (specify): ______________________

4. Please list your child’s current medications (including vitamins, over-the-counter medications):

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How often</th>
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5. Has your child ever been hospitalized or required surgery?  Yes  No

If yes, please explain and give dates: ____________________________________________

6. Are your child’s immunizations up to date?  Yes  No

7. What was your child’s weight at his/her most recent visit with the pediatrician?  ________________

E. FAMILY HISTORY

Are there any medical problems that run in the family (parents, siblings, grandparents)?

- Cystic fibrosis
- Lung disease
- Stomach ulcers
- Thyroid disease
- Developmental delay
- Diabetes
- Drug/alcohol use/abuse
- Celiac sprue disease
- Crohn’s disease
- Liver disease/cirrhosis
- Allergies
- Learning disabilities
- Heart Disease
- Ulcerative colitis
- GE reflux
- Spastic colon/irritable bowel
- Asthma
- Genetic abnormalities
- Mental health
- Other (specify): ______________________
**F. FEEDING HISTORY**

1. How was your child fed as an infant? breast   bottle

2. How long did your child receive breast milk? ________________________________

3. Did your child have any difficulties with breast feeding or bottle feeding? Yes No
   If yes, please describe ____________________________________________________

4. How many infant formulas did you use? ________________________________
   Please list: ___________________________________________________________________

5. Did your child ever take a pacifier? Yes No

6. At what age did your child eat baby food from a spoon? ________________________________
   Did he/she have difficulty? Yes No - If yes, please explain:
   __________________________________________________________________________

7. Does your child have any teeth? If so, how many? _______
   a. Does your child tolerate toothbrushing? Yes No

**G. EATING ENVIRONMENT**

1. Where does your child usually sit during mealtimes?
   - Infant seat
   - Highchair
   - In front of TV
   - Child stands
   - Child wanders around
   - Chair at table
   - On caretakers’ lap
   - Booster seat
   - Held in caretaker’s arms
   - Other: __________________________________________________________________

2. Where in the house if your child fed?
   - Kitchen
   - Dining room
   - Living room
   - Walking around
   - Other (specify): __________________________________________________________________

3. With whom does your child usually eat/drink?
   - Alone
   - With parents
   - With siblings
   - With peers
   - With nurse

4. At what other locations does your child eat/drink?
   - Daycare
   - School
   - Other relative’s home
   - Restaurants
   - In the car
5. Does your child tend to eat better while standing vs. sitting?  
   Yes  No

6. Does your child do any of the following during mealtime?
   - Apple: Refuse to eat
   - Apple: Spits out food
   - Apple: Cries/screams
   - Apple: Vomits
   - Apple: Falls asleep
   - Apple: Gags/coughs
   - Apple: Holds food in mouth
   - Apple: Throws food/utensils
   - Apple: Tries to get out of seat

H. CURRENT FEEDING/DRINKING SKILLS

1. Who feeds your child?
   - Apple: Mother
   - Apple: Father
   - Apple: Sibling
   - Apple: Grandparent
   - Apple: Nurse
   - Apple: Teacher
   - Apple: Daycare provider
   - Other (specify): ____________________

2. Please note your child’s current feeding skills:
   a. Spoon fed?  Yes  No  - If yes, type of spoon: _________________________
   b. Child feeds self?  Yes  No
      Finger feeding:  beginning partially successful completely successful
      Feeds self with spoon:  beginning partially successful completely successful
   c. Drinking from breast?  Yes  No
   d. Drinking from a bottle?  Yes  No  Holds own bottle?  Yes  No
      If yes, what type of nipple:
      regular  orthodontic  other (specify): _________________________
      slow  medium  fast
   e. How is your child positioned during feeding?
      seated  held  other (specify): _________________________
   f. When is the bottle/breast offered? _________________________
   g. Drinking from a cup?  Yes  No  - If yes, type of cup: _________________________
   h. Straw drinking?  Yes  No

3. What types of liquid does your child drink? _________________________

4. How much liquid does your child drink per day?
   0-8 oz  8-16 oz  16-24 oz  24-32 oz  32-40 oz  >40 oz
Food Textures

1. Please check (✓) your child’s current ability to eat a variety of food textures:

<table>
<thead>
<tr>
<th>Texture</th>
<th>Eats easily</th>
<th>Eats with difficulty</th>
<th>Refuses</th>
<th>Cannot eat</th>
<th>Never tried</th>
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<tbody>
<tr>
<td>Baby food</td>
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<td>Puree table food</td>
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<td>Mashed table food</td>
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<td>Soft finger solids</td>
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<td>Chopped table food</td>
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<td>Soft table food (e.g. pancakes)</td>
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<tr>
<td>Crunchy table food (e.g. apples, crackers)</td>
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<tr>
<td>Difficult to chew table food (e.g. meat)</td>
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2. Please give examples of food your child will eat from all food groups:

<table>
<thead>
<tr>
<th>Food Group</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Fruit</td>
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<tr>
<td>Grains (bread/cereal/pasta/rice)</td>
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<td>Vegetables</td>
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<td>Meats/egg/peanut butter</td>
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<td>Dairy (milk/cheese/yogurt)</td>
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3. Does your child prefer foods that are: Room temp Hot Cold

Tube Feeding Assessment

1. Does your child receive tube feeds: Yes No (If not, please skip this section)

2. What is the name and specialty of the Provider who tells you what to give through the tube?

3. Type of tube used: NG G G-J

4. Formula used: ________________________________________________________________

5. Schedule: (Include times and amount given) ____________________________________
I. DIET ASSESSMENT

Please list everything your child might eat or drink during a typical day. Describe all food, formula, drinks, snacks, food extras (butter, oil, salad dressing) and the amounts consumed.

<table>
<thead>
<tr>
<th>Example: Stage 2 carrots</th>
<th>4 ounce jar</th>
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<tr>
<td>Example: whole milk with heavy cream</td>
<td>6 ounces + 1 tablespoon</td>
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<tr>
<td>Example: Chewy granola bar</td>
<td>¼ of the bar</td>
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<thead>
<tr>
<th>Breakfast:</th>
<th>Amounts of food and drink child actually eats/drinks</th>
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<th>Lunch:</th>
<th>Amounts of food and drink child actually eats/drinks</th>
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<th>Snack:</th>
<th>Amounts of food and drink child actually eats/drinks</th>
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<th>Dinner:</th>
<th>Amounts of food and drink child actually eats/drinks</th>
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Accepted Foods:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Sometimes Foods that child had and lost:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Rejected Foods:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Is any adaptive equipment being used during feedings? __________________________________________

J. BEHAVIOR

Please indicate any of the following concerns that you or others who spend time with the child (i.e. teacher, daycare) may have:

- Has difficulty transitioning between activities
- Is easily upset
- Is easily distracted
- Does not like to be touched
- Has a high activity level
- Has difficulty calming down when upset
- Is irritable or cranky

Please describe: _________________________________________________________________________
*References

American Speech-Language-Hearing Association. (2015). *Pediatric Feeding History and Clinical Assessment Form (Infant 6 months and older).*