Huntington Speech and Feeding

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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:

None Mild Moderate Severe

0 1 2 3 4 5 6 7 8 9 10

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
- Abnormal ultrasound
- Preterm labor
- Infection
- Eclampsia/pre-eclampsia
- 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

Name of Specialist	Specialty	Location	Date last seen

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):

Medication	Dose	How often

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?

- Refuse to eat
- Spits out food
- Cries/screams
- Vomits
- Falls asleep
- Gags/coughs
- Holds food in mouth
- Throws food/utensils
- Tries to get out of seat

H. CURRENT FEEDING/DRINKING SKILLS

1. Who feeds your child?

- Mother
- Father
- Sibling
- Grandparent
- Nurse
- Teacher
- 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
      How is your child positioned during feeding?

      ☐ seated ☐ held ☐ other (specify): _____

   e. When is the bottle/breast offered? _____

   f. Drinking from a cup? ☐ Yes ☐ No - If yes, type of cup:_____

   g. 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:

Texture	Eats easily	Eats with difficulty	Refuses	Cannot eat	Never tried
Baby food					
Puree table food					
Mashed table food					
Soft finger solids					
Chopped table food					
Soft table food (e.g. pancakes)					
Crunchy table food (e.g. apples, crackers)					
Difficult to chew table food (e.g. meat)					

2. Please give examples of food your child will eat from all food groups:

Food Group	Examples
Fruit	_____
Grains (bread/cereal/pasta/rice)	_____
Vegetables	_____
Meats/egg/peanut butter	_____
Dairy (milk/cheese/yogurt)	_____

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.

Example: Stage 2 carrots	4 ounce jar
Example: whole milk with heavy cream	6 ounces + 1 tablespoon
Example: Chewy granola bar	¼ of the bar

Breakfast:	**Amounts of food and drink child actually eats/drinks**

Lunch:	**Amounts of food and drink child actually eats/drinks**

Snack:	**Amounts of food and drink child actually eats/drinks**

Dinner:	**Amounts of food and drink child actually eats/drinks**

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).*