



Pediatric Therapy Partners

PHYSICAL THERAPY • OCCUPATIONAL THERAPY • SPEECH-LANGUAGE THERAPY

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PEDIATRIC FEEDING HISTORY FORM

CHILD'S NAME: _____ DATE OF BIRTH: _____

1. Please explain, in your own words, what your child's current feeding problem is:
2. Was your child breastfed? From when to when _____
Was your child bottle fed? From when to when _____
Please identify type of bottle and type of nipple used _____
Did feedings take an unusual amount of time? _____ If so, how long? _____
3. During these early feedings, did your child frequently arch, cry, spit-up, gag, cough, vomit or pull off the nipple?
Circle the behaviors shown and describe when they would happen, why, and 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 foods? _____
Please describe how these transitions were handled by your child, especially if any difficulties happened:

IF YOUR CHILD EATS BY MOUTH, PLEASE ANSWER THE FOLLOWING QUESTIONS:

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 the foods your child is allergic to:

6d. Describe your child's mealtime:

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 sit for the entire meal? _____ If not, please describe: _____

Does your child finger feed? _____ Does your child use utensils? _____

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, and 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:

<u>Time of feeding</u>	<u>NG, G or Continuous</u>	<u>Amount</u>	<u>Gravity of Pump</u>	<u>Over what time period or what rate</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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? _____
If yes, please describe type of diet, at what ages, why and what your child's response was:
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 (circle one): Ideal Underweight Overweight
12. Does your child have/had any of the following problems? Please describe:
Dental, frequent constipation, frequent diarrhea, vomiting, choking, gagging, coughing
13. Does your child take a vitamin supplement? 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 or what were your recommendations?
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?