

The Pauline K. Winkler

Speech-Language-Hearing Center

 at

 The College of Saint Rose

 432 Western Avenue

 Albany, NY 12203

 (518) 337-4914 / Fax: (518) 337-2313

Director of Clinical Services, Melissa Spring, M.S., CCC-SLP

Coordinator of the Winkler Center, Grace Paster, M.A., CCC-SLP

Coordinator of Early Intervention & Preschool Services

**Feeding Case History Form**

# **General Information**

Child’s Name: Click or tap here to enter text. Date of Birth: M / D / Y

Address: Street Home Phone: ( ### ) ### - ####

 City, State, Zip Code Cell: ( ### ) ### - ####

Parent/Guardian’s Name: Click or tap here to enter text. Occupation: Click or tap to enter text.

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Does the child live with his/her parents? Click or tap here to enter text.

Please list all other people living in the child's home:

|  |  |  |
| --- | --- | --- |
| **Name** | **Age** | **Relationship** |
| Click or tap here to enter text. | Age | Click or tap here to enter text. |
| Click or tap here to enter text. | Age | Click or tap here to enter text. |
| Click or tap here to enter text. | Age | Click or tap here to enter text. |
| Click or tap here to enter text. | Age | Click or tap here to enter text. |

Primary Language spoken at home: Click or tap here to enter text.

Any other languages spoken in the house: Click or tap here to enter text.

Who referred you to the Winkler center and what were the primary reasons?

 Click or tap here to enter text.

# **Prenatal and Birth History**

Length of Pregnancy: Click or tap here to enter text.

Type of Delivery: Click or tap here to enter text.

Please explain any complications or unusual conditions that may have affected the pregnancy or birth.

 Click or tap here to enter text.

Did your child stay in the Neonatal ICU? Click or tap here to enter text.

 How long? Click or tap here to enter text.

 What was the reason for their stay? Click or tap here to enter text.

Describe any of your child’s feeding difficulties as an infant.

 Click or tap here to enter text.

Describe any respiratory or gastrointestinal issues as an infant.

 Click or tap here to enter text.

Medical diagnoses: Click or tap here to enter text.

# **Medical History**

Child's Primary Care Physician: Click or tap here to enter text.

 Phone: ( ### ) ### - ####

 Address: Street

 City, State, Zip Code

Has your child ever had surgeries, hospitalizations, or serious injury? If yes, please list below.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Procedure/ Reason** | **Hospital** | **Length of Stay** |
| M / D / Y | Click or tap here to enter text. | Click or tap here to enter text. | Length of stay. |
| M / D / Y | Click or tap here to enter text. | Click or tap here to enter text. | Length of stay. |
| M / D / Y | Click or tap here to enter text. | Click or tap here to enter text. | Length of stay. |

Please list any current medications:

Name: Medicine Dose: Dose Name: Medicine Dose: Dose

Name: Medicine Dose: Dose Name: Medicine Dose: Dose

Name: Medicine Dose: Dose Name: Medicine Dose: Dose

Please list all other specialists (nutritionist, gastroenterologist, etc.) treating your child.

 Click or tap here to enter text.

Has your child had any allergy tests? (blood, skin prick, skin patch, endoscopies)

 Click or tap here to enter text.

Does your child have any allergies? Any food allergies?

 Click or tap here to enter text.

Has your child been diagnosed with a developmental disability or as having behavior problems?

 Click or tap here to enter text.

Has your child been diagnosed with any of the following? Check all that apply.

[ ]  GE Reflux [ ]  Cardiac Issues [ ]  Pulmonary Issues

[ ]  ADD / ADHD [ ]  Mental Health [ ]  Neurologic Issues

[ ]  Autism / PDD [ ]  Diarrhea [ ]  Constipation

[ ]  Esophagitis [ ]  Motor Delay [ ]  Cleft Lip/Palate

[ ]  Aggressive Behavior [ ]  Developmental Delay [ ]  Oppositional Behavior

[ ]  Failure to Thrive / Slow Growth [ ]  Genetic / Chromosomal Abnormality

[ ]  Other (please specify) Click or tap here to enter text.

Has your child had any of the following medical tests done?

[ ]  Upper GI Series [ ]  Endoscopy [ ]  Genetic Testing

[ ]  Milk Scan [ ]  Modified Barium Swallow Study

[ ]  Other (please specify) Click or tap here to enter text.

Child’s Current Height: Click or tap here to enter text.

Child’s Current Weight: Click or tap here to enter text.

How would you describe your child’s weight?

 [ ]  Ideal [ ]  Underweight [ ]  Overweight

**Feeding History**

What modes of feeing do you currently use, or have you used in the past?

|  |  |  |
| --- | --- | --- |
| **Feeding Method** | **Age introduced / How long?** | **Any problems noted / Comments** |
| **Breast fed** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Bottle fed** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Finger feed** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Cereals/baby foods** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Table foods** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Spoon** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Fork** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Knife** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Straw drinking** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Sippy cup** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Open cup drinking** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Feeding tube (G-tube, NG tube, NJ tube)** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Other** | Click or tap here to enter text. | Click or tap here to enter text. |

Please list various foods, flavors, textures that are favorites/easy or dislikes/difficult.

|  |  |
| --- | --- |
| **Favorites/Easy** | **Dislikes/Refuses/Difficult** |
| Click or tap here to enter text. | Click or tap here to enter text. |

Does your child display any of the following? Please check all that apply and indicate when the problem started.

[ ]  Food refusal (of all or most foods) Age? Age

[ ]  Food selectivity by texture Age? Age

[ ]  Food selectivity by type (limited variety) Age? Age

[ ]  Abnormal preferences (temperature sensitive, Age? Age

 color specific, etc.)

[ ]  Difficulty swallowing (Dysphagia) Age? Age

[ ]  Other: Click or tap here to enter text. Age? Age

Where does your child usually feed? Check all that apply.

[ ]  Lap [ ]  Infant Seat [ ]  Table / Chair [ ]  Floor

[ ]  Highchair [ ]  Couch [ ]  Stand / Roam

[ ]  Other: Click or tap here to enter text.

Are your child’s feet supported while they are eating? (Touching the ground, supported by footrest, etc.)

 Click or tap here to enter text.

How does your child let you know he/she is hungry?

 Click or tap here to enter text.

How long do meals typically last?

 Click or tap here to enter text.

How much food is your child able to finish in a typical meal?

 Click or tap here to enter text.

# **Feeding Status**

What are your major concerns regarding your child’s feeding?

 Click or tap here to enter text.

Describe your child's regular feeding schedule.

 Click or tap here to enter text.

Who usually feeds your child?

 Click or tap here to enter text.

Please list any food allergies.

 Click or tap here to enter text.

Please list preferred foods.

 Click or tap here to enter text.

Please list non-preferred foods.

 Click or tap here to enter text.

Please check any difficulty your child has during mealtime.

[ ]  Drooling [ ]  Choking [ ]  Gagging [ ]  Biting

[ ]  Vomiting [ ]  Coughing [ ]  Chewing [ ]  Swallowing

[ ]  Reflux [ ]  Teeth grinding [ ]  Fails to chew [ ]  Penetration / aspiration

[ ]  Food or liquid coming out of nose [ ]  Hypersensitivity to textures or temperatures

[ ]  Continuous sucking / Poor sucking [ ]  Lip control (keeping mouth closed)

[ ]  Tongue control (thrust or poor mobility

[ ]  Other: Click or tap here to enter text.

Please check any behaviors that are of concern during mealtime.

[ ]  Eats too fast [ ]  Eats non-food items [ ]  Pushes away foods

[ ]  Eats too much [ ]  Uses a bottle [ ]  Refuses to open mouth

[ ]  Eats too little [ ]  Spits food out [ ]  Leaves table

[ ]  Eats too slow [ ]  Throws or drops food [ ]  Cries or tantrums

[ ]  Turns away from food [ ]  Sneaks / Steals food [ ]  Plays with food

[ ]  Only eats certain foods [ ]  Messy eater [ ]  Holds food in mouth

[ ]  Falls asleep or fatigues [ ]  Over stuffing mouth

[ ]  Other: Click or tap here to enter text.

Check the square for any of the feeding techniques you use with your child to get him/her to eat. Check the circle for any of the techniques that are affective.

[ ]  [ ]  Offer reward [ ]  [ ]  Sent to time out [ ]  [ ]  Distract with toys / tv / ipad

[ ]  [ ]  Praise [ ]  [ ]  Force feed [ ]  [ ]  Threaten “if you don’t eat…”

[ ]  [ ]  Ignore [ ]  [ ]  Allow roaming [ ]  [ ]  Change meal schedule

[ ]  [ ]  Punish [ ]  [ ]  Change foods [ ]  [ ]  Coax

[ ]  [ ]  Offer food throughout the day [ ]  [ ]  Serve only preferred foods

[ ]  [ ]  Other: Click or tap here to enter text.

What does your child drink from? Check all that apply.

[ ]  Bottle [ ]  Sippy cup [ ]  Open cup [ ]  Straw

Does your child take oral supplements or caloric boosters? Click or tap here to enter text.

Is your child able to self-feed? Click or tap here to enter text.

List any foods *consistently* accepted in the following categories:

|  |  |
| --- | --- |
| **Fruits** | Click or tap here to enter text. |
| **Meats** | Click or tap here to enter text. |
| **Breads/Cereals** | Click or tap here to enter text. |
| **Vegetables** | Click or tap here to enter text. |
| **Dairy Products** | Click or tap here to enter text. |
| **Sweets** | Click or tap here to enter text. |
| **Snacks** | Click or tap here to enter text. |
| **Beverages** | Click or tap here to enter text. |

# **Reason for Referral**

What is your major feeding concern that prompted this evaluation to be completed?

 Click or tap here to enter text.

What are your feeding goals for your child?

 Click or tap here to enter text.

Check any other feeding goals that apply.

[ ]  Increase amount of food [ ]  Increase variety of food [ ]  Decrease / eliminate tube feeds

[ ]  Improve oral motor skills [ ]  Increased weight gain [ ]  Increase the textures of foods

 [ ]  Improve mealtime behaviors [ ]  Decrease vomiting related to feeding

 [ ]  Resolve reflux or other GI issues [ ]  Decrease gagging during eating

[ ]  Other: Click or tap here to enter text.

# **Developmental History**

Please provide at what age your child began to do the following activities:

 Sit Enter text here. Crawl Enter text here. Walk Enter text here.

First words Enter text here. Sentences Enter text here. Toilet trained Enter text here.

Is your child currently receiving or have received any other services or evaluations (Physical Therapy, Occupational Therapy, Speech-Language Therapy, etc.)?

 Click or tap here to enter text.

# **Education**

Is your child currently enrolled in school or daycare? Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Enter text here.

Are there specific feeding issues at school?

 Click or tap here to enter text.

Are there any educational or academic concerns at this time?

 Click or tap here to enter text.

Please provide any addition information you feel may be helpful during this evaluation.

 Click or tap here to enter text.

Name of person completing this form: Click or tap here to enter text.

 Relationship to child: Click or tap here to enter text.

Signature: Click or tap here to sign. Date: M / D / Y

Five Day Food Journal

Include all liquids and solids

Indicate the amount the child ate/drank (ounces)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Day 1** | **Day 2** | **Day 3** | **Day 4** | **Day 5** |
| **Breakfast** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Snack** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Lunch** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Snack** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Supper** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Snack** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |