Feeding Evaluation History Form

Date:	Primary Care Physician:	Referred by:
Patient Name:	DOB:	Therapist:

HI	STORY	
Purpose of the evaluation:	Medical History:	
□ Oral aversion	List Current Medical diagnoses – See patient history form	
□ Food refusal	List Surgeries and Hospitalizations on patient history form	
□ Transition to solids	□ Esophageal Reflux	
□ Choking/coughing with eating or drinking	□ Nasal Reflux	
□ Gagging or vomiting when eating	□ Drooling	
Accepting liquids by mouth	□ Upper GI Testing Done –results	
Accepting solids by mouth	Modified Barium Swallow Study (MBS)	
□ Reduced variety	Date of most recent MBS//	
□ Reduced volume	Results	
☐ Follow up to a swallow study (MBS or FEES)	☐ Fiberoptic Endoscopic Evaluation of Swallowing, (FEES)	
□ Nutritional concerns	Date of most recent FEES//	
□ Failure to thrive	Results	
Other	Constipation	
Current Medications: See patient history form	□ Diarrhea/Loose Stools	
Allergies/Intolerances: including any food, environmental		
medicines, and any other:	□ Asthma	
□ None	 Respiratory Status (including rapid breathing, sternal 	
□ Yes,	retractions, noisy breathing, history of pneuomonia,	
Birth History: Weight at birthlbs,oz.	cyanosis) need for supplemental	
□ No complications with pregnancy or delivery,	oxygen):	
□ Complications with pregnancy	☐ History of intubation	
Complications with delivery	□ Cardiac Status:	
☐ Premature , born at weeks gestation	Rashes or skin redness after eating or drinking	
□ Stayed in NICU for	□ See additional history on patient history form	
Past Feeding History: Route of Nutrition:	Current Feeding Difficulties:	
□ Oral;	□ Difficulties with Breast feeding,,	
☐ Oral + non-oral (NG, NJ, GJ, GT, OG, OJ),	□ With transitions to;	
□ Non-oral (NG, NJ, GJ, GT, OG, OJ),	□ Controlling liquids,	
Other	☐ Managing or accepting solids;	
Past Feeding Difficulties:	Current Eating/Oral Feeding Schedule:	
□ Difficulties with Breast feeding,;	□times a day,	
□ With transitions to;	□ Every hours,	
□ Controlling liquids;	□ Other;	
□ Managing or accepting solids	Current Non-oral Feeding Schedule:	
□ Family History of feeding problems, intolerances or	□ Continuous, (rate for how long)	
allergies: Please list:	; Bolus (every hours, volume, Frequency,	
Current Feeding Status- Route of Nutrition:	Length of Feeding, Pump or syringe (gravity)	
□ Oral;	□ Other	
□ Oral + non-oral; (NG, NJ, GJ, GT, OG, OJ),	Time it takes for each feeding:	
□ Non-oral (NG, NJ, GJ, GT, OG, OJ),	□ Who feeds the child:	
□ Other	Does he/she eat better for certain people?	
	□ Does he/she eat better at particular times of the day?	
	☐ Is feeding worse at the beginning/middle/end of feeding?	

Current diet: Ulquids	PATIENT NAME:		
□ Formula (type) □ Breast milk; □ Cow's milk; □ Soy Milk; □ Other liquids □ Quantity of liquid per day ounces; □ Use of liquid thickeners: yes/no; if yes, what type? Solids: Types/quantities of food eaten for meals: □ Not developmentally appropriate. Breakfast: □ Lunch: □ Sinacks: □ Dinner: □ Other foods your child has tried 1-2 times before but does not regularly eat: □ Child's response to Feeding: □ At counter/bar, □ At counter/bar, □ Needs Distraction: List types □ Needs Distraction: List types □ Does your child report a burning or painful sensation in the chest or throat area during or after eating? □ Does your child complain about stomach pains? □ Have woften does your child complain about feeling like vomiting? □ How often does your child complain about feeling like vomiting? □ Does your child to they vomit? □ How often does your child at a too little or get full before finishing the meal? □ Does your child wake up at night with belly pain? □ Have you ever noticed blood in his or her tool during the last three months?	Current diet:		
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