Feeding Evaluation History Form

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

HISTORY

Purpose of the evaluation:

- ❑ Oral aversion
- ❑ Food refusal
- ❑ Transition to solids
- ❑ Choking/coughing with eating or drinking
- ❑ Gagging or vomiting when eating
- ❑ Accepting liquids by mouth
- ❑ Accepting solids by mouth
- ❑ Reduced variety
- ❑ Reduced volume
- ❑ Follow up to a swallow study (MBS or FEES)
- ❑ Nutritional concerns
- ❑ Failure to thrive
- ❑ Other _____

Current Medications: See patient history form

Allergies/Intolerances: including any food, environmental, medicines, and any other:

- ❑ None
- ❑ Yes, _____

Birth History: Weight at birth ____lbs, ____oz.

- ❑ No complications with pregnancy or delivery,
- ❑ Complications with pregnancy_____
- ❑ Complications with delivery _____
- ❑ Premature , born at ___ weeks gestation
- ❑ Stayed in NICU for _____

Medical History:

List Current Medical diagnoses – See patient history form

List Surgeries and Hospitalizations on patient history form

- ❑ Esophageal Reflux
- ❑ Nasal Reflux
- ❑ Drooling
- ❑ Upper GI Testing Done –results_____
- ❑ Modified Barium Swallow Study (MBS)
  Date of most recent MBS ___/___/____
  Results_____
- ❑ Fiberoptic Endoscopic Evaluation of Swallowing, (FEES)
  Date of most recent FEES___/___/____
  Results _____
- ❑ Constipation _____
- ❑ Diarrhea/Loose Stools _____
- ❑ Belching/Burping excessively
- ❑ Asthma _____
- ❑ Respiratory Status (including rapid breathing, sternal retractions, noisy breathing, history of pneuomonia, cyanosis) need for supplemental oxygen):_____
- ❑ History of intubation
- ❑ Cardiac Status: _____
- ❑ Rashes or skin redness after eating or drinking_____
- ❑ See additional history on patient history form

Past Feeding History: Route of Nutrition**:**

- ❑ Oral;
- ❑ Oral + non-oral (NG, NJ, GJ, GT, OG, OJ),
- ❑ Non-oral (NG, NJ, GJ, GT, OG, OJ),
- ❑ Other _____;

Past Feeding Difficulties:

- ❑ Difficulties with Breast feeding, _____;
- ❑ With transitions to _____;
- ❑ Controlling liquids _____;
- ❑ Managing or accepting solids _____;
- ❑ **Family History of feeding problems, intolerances or allergies:** Please list:_____;

Current Feeding Status- Route of Nutrition**:**

- ❑ Oral;
- ❑ Oral + non-oral; (NG, NJ, GJ, GT, OG, OJ),
- ❑ Non-oral (NG, NJ, GJ, GT, OG, OJ),
- ❑ Other _____;

Current Feeding Difficulties:

- ❑ Difficulties with Breast feeding, _____,
- ❑ With transitions to _____;
- ❑ Controlling liquids _____,
- ❑ Managing or accepting solids _____;

Current Eating/Oral Feeding Schedule:

- ❑ _____times a day,
- ❑ Every _____ hours,
- ❑ Other _____;

Current Non-oral Feeding Schedule:

- ❑ Continuous, (rate_____ for how long_____)
- ❑ Bolus (every ___ hours, volume____, Frequency ____, Length of Feeding _____, Pump or syringe (gravity)
- ❑ Other _____.

Time it takes for each feeding: **_____**

- ❑ Who feeds the child:_____
- ❑ 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? _____

PATIENT NAME:

Current diet:

Liquids

- ❑ 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:_____

_____

Snacks:_____

_____

Dinner:_____

_____.

Other foods your child has tried 1-2 times before but does not regularly eat:_____

_____.

Eating Routine:

- ❑ High Chair,
- ❑ Car Seat,
- ❑ Table,
- ❑ At counter/bar,
- ❑ With Family Members,
- ❑ Needs Distraction : List types_____

Reported Self Feeding Skills:

- ❑ Bottle (6+ months)
- ❑ Fingers (14-16 months)
- ❑ Spoon(14-30 months)
- ❑ Fork (14-36 months)
- ❑ Sippy Cup
- ❑ Open Cup
- ❑ Straw

Other _____

Child's response to Feeding:

- ❑ 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?
- ❑ How often does your child complain about feeling like vomiting?
- ❑ How often do they vomit?
- ❑ How often does your child eat 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?

Sleep patterns:

- ❑ Nap and sleep schedule
- ❑ Is your child a restless sleeper
- ❑ Is your child unusually tired during the day?
- ❑ Does your child fall asleep at school?
- ❑ Does your child have "accidents" during the night?
- ❑ History of sleep apnea?

Comments: