



**FEEDING HISTORY FORM**

**CHILD'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**Person Completing History:**  Mother  Father  Self  Other (specify) \_\_\_\_\_

**Child's Physicians and other Professionals:**

PCP: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

GI: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Nutritionist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Other: \_\_\_\_\_ Profession: \_\_\_\_\_ Phone: \_\_\_\_\_

**General Information:**

1. Please explain in your own words, what are your child's current feeding problem(s):  
 \_\_\_\_\_
  
2. Was your child breast fed?  YES  NO from when to when? \_\_\_\_\_  
 Was your child bottle fed?  YES  NO from when to when? \_\_\_\_\_  
 Please describe your child's initial skill on the breast and/or bottle:  
 \_\_\_\_\_
  
3. During these early feedings, did your child frequently  arch,  cry,  spit up,  gag,  cough,  vomit or  
 pull off the nipple? Check the behaviors shown and describe when they would happen, why, 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 food? \_\_\_\_\_  
 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 any foods that your child ate but will not longer eat:

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 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, 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<br/>(start time)</u> | <u>NG, G or Continuous</u> | <u>Amount</u> | <u>Gravity or Pump</u> | <u>Over what time period<br/>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?  YES  NO  
If yes, please describe type of diet, at what ages, why and what was your child's response:

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:  Ideal  Underweight  Overweight
12. Does your child have/had any of the following problems?  dental,  frequent constipation,  
 frequent diarrhea,  vomiting,  choking,  gagging,  coughing. Please describe:
13. Does your child take a vitamin supplement?  YES  NO 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/what were you told?
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?