INTEGRATED CHILDREN'S THERAPIES, INC.

where children make connections

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: _____

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

List the foods that your child currently will eat and drink, flavors, and if they need to be prepared in a certain way how they are prepared (pureed together, only with a sauce, etc. **Please put a star next to their favorites**.

PROTEINS (MEATS, LENTILS, YOGURT, CHEESE, ETC)	**FRUITS/ VEGETABLES**	**STARCHES** (BREAD, CRACKERS, ETC.)	**LIQUIDS** (MILK, TYPE OF JUICE, PEDIASURE, ETC.)

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Please explain, what are your child's current feeding problem(s): _____

_____

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: _____

_____

During these early feedings, did your child frequently:

☐ arch ☐ cry ☐ spit up ☐ gag ☐ cough ☐ vomit or ☐ pull off the nipple?

Please describe the above behaviors and when they would happen, why, and for how long:

_____

_____

Describe how the weaning process off the breast and/or bottle went and why the child was weaned: _____

_____

At what age did your child transition to:

Baby Cereal _____ Baby Food _____ Finger Food _____ Fully to Table Foods _____

Please describe how these transitions were handled by your child, especially if any difficulties occurred: _____

_____

Please list any foods that your child ate but will no longer eat: _____

_____

Please list any foods that your child is allergic to: _____

_____

CHILD'S CURRENT MEALTIME:

Who typically feeds your child? _____

Who typically eats with your child? _____

What type of chair is used and is it adapted?
(e.g., reclining, side support, etc.) _____

Where does your child typically eat?
(e.g., dining table, couch, etc.) _____

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, do they need to be distracted, do you use a specific routine, etc.

_____

_____

What times does your child typically eat and what type (liquids, solids, etc.):
Please note, if your child is G-tube fed, please indicate the type of feed and schedule in addition to any oral foods.

TIME (AM/PM)	BREAKFAST, LUNCH, DINNER, SNACK

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, why and what was your child's response: _____

_____

_____

Has your child lost or gained any weight in the last 6 months, and if so, how much? _____

_____

Currently, would you describe your child's weight as ☐ Ideal ☐Underweight ☐ Overweight

Currently, does your child have/had any of the following problems?

☐Dental Issues ☐Frequent constipation ☐Frequent diarrhea ☐Vomiting ☐Choking ☐Gagging ☐Coughing

Please describe: _____

_____

Currently does your child take a vitamin supplement. ☐ YES ☐ NO

Describe how you and your child feel after your child's meal:

You: _____

Your child: _____

Over the past, other than at ICT, have other evaluations have been completed regarding your child's feeding difficulties or for some other concern? (e.g., swallow studies, neuropsychology evaluations, etc.) ☐ YES ☐ NO
If so, for what and what were the results? _____

Please complete the three-day food diary:

Day 1

MEAL	FOODS AND AMOUNTS EATEN
Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	

Day 2

MEAL	FOOD AND AMOUNTS EATEN
Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	

Day 3

MEAL	FOOD AND AMOUNTS EATEN
Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	