ONSLOW MEMORIAL HOSPITAL
Rehabilitation Services **PEDIATRIC FEEDING HISTORY- Page 1 of 2**

CHILD'S Name: _____ Age: _____ Physician:_____

History/Diagnosis of GERD / Reflux? : *(circle)* Y N When?_____Diagnosed by: _____

Treatment for Reflux? ___Y ___N Type of Treatment: _____Treatment effective? ____Y ____ N

Was there a time when you did not or were not able to give your child food or fluids by mouth? ____Y ___ N

For how long? _____ How old was your child at the time?_____

Why? *(check all that apply*) ___ premature birth ___ surgery ___ craniofacial issues ___ oral motor difficulties ___medical/respiratory issues

Please check if your child has had any of the following: ___MBS (swallow study) ___Endoscopy ___ Upper GI ___ allergy testing ___ pH probe

___ tracheostomy ___ nasal cannula ___ NG tube ___G tube

TUBE FEEDING (if applicable): Formula Type:_____ Method: __Pump __ Gravity __ Bolus Rate: _____

Schedule: Times /Amount _____

ELIMINATION PATTERNS AND HABITS*:*
Urinary Frequency: times per day _____ Frequency of Bowel Movements per day _____ per week _____ Constipation? ____Y ____ N

ORAL FEEDING: *Infancy:* *(check all that apply)* ___breast fed ___bottle fed ___ both ___ tube fed: for how long?_____

When bottle or breast fed, my child: ___drank very little ___drank about half ___ drank most of feedings

When your child transitioned to solid foods, indicate his/her age and how well each food was accepted.

TYPE OF FOOD	CHILD'S AGE	ACCEPTANCE (check one)	
Baby Cereal	_____	€ refused	€ accepted
Baby Foods: Fruit	_____	€ refused	€ accepted
Vegetables	_____	€ refused	€ accepted
Meats	_____	€ refused	€ accepted
Mixed Meals	_____	€ refused	€ accepted
Mashed Table Foods	_____	€ refused	€ accepted
Regular Table Food	_____	€ refused	€ accepted

As an infant (under 12 months), what food type and consistency did he/she accept best? _____

CURRENTLY:
Does your child have a special diet? ____ Y ____N If yes, describe:_____

Your child's appetite is best described as: ___ poor ___ fair ___good ___excellent ___ eats too much ___ doesn't eat much ___ picky eater

Does your child tell you when he or she is hungry? ___ Y ___ N If yes, how? (check) ___ fussing/whining/crying (you need to guess)

___ points at food/refrigerator/cupboard, ___takes me to food source, ___ tells me what he/she wants, ___ gets food for self

Provide a general sample of when, where what, and how much your child eats at each meal.

Meal	Time	Location	Food Type	Approx. Amount
Breakfast				
a.m. Snack				
Lunch				
p.m. Snack				
Dinner				
Other Snack				

Right now, my child:

Eats in:
___ my lap
___ a child seat / carrier
___ high chair
___ booster seat
___ regular chair

Eats:
___ or is fed alone
___ with the rest of the family

Takes (to finish a meal):
___less than 10 min.
___ 10-20 minutes
___20-30 minutes
___30-40 minutes
___40-60 minutes
___more than 60 min.

___drinks from bottle
___drinks from cup/glass
___drinks from straw
___is fed by care giver(s)
___feeds self with fingers
___feeds self with spoon ___ fork ___able to use knife
___gets/ prepares own snack

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PEDIATRIC FEEDING HISTORY- Page 2 of 2

Child's Name: _____

Check all that apply for your child right now:

Food Textures	Eats most of the time	ABLE to eat, but may not want to	Rarely/never WILL eat when served	CANNOT eat, even if he/she wants to	Has not tried / has never been given
Liquids					
Baby food					
Creamy foods					
Blended table foods					
Mashed table foods					
Chopped table foods					
Regular table foods					
Crispy foods (crackers, toast)					
Chewy foods (meat, gummies)					
Crunchy foods (carrots, apples)					

Write down the foods that your child will **USUALLY** eat when you serve them for snacks or meals.

Fruits: _____Vegetables:_____

Meats: _____ Starches: _____

Liquids: _____ Junk Food: _____

Does your child's food habits/preferences match the family? __Y __ N Little snacks & meals thru day? __Y __N

ORAL MOTOR BEHAVIORS: *Please check all that apply*.

Problem	Had in the Past	Continues to Have	Problem	Had in the Past	Continues to Have
Poor / weak sucking			Gagging –certain foods /drinks		
Drooling / pooling of saliva			Teeth Grinding		
Open mouth posture while at rest			Grunting		
Difficulty biting off pieces of food			Coughing –certain foods/ drinks		
Difficulty manipulating food in mouth – spits out food			Profuse perspiration		
Difficulty swallowing solid foods			Choking episodes		
Difficulty chewing (if over 12 months)			Aspiration		
Over sensitivity to food textures			Vomiting		
Over sensitivity to food temperatures					
Oversensitivity to eating or drinking utensils (spoon, straws, sippee cups, etc.)					

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Please describe what you think works best for your child.

Type of bottle or cup_____ Type of bowl, plate or eating utensils_____

Eating location and/or position_____ ___No preference noted

In your own words, please describe your concerns about your child's problem. _____

_____

_____

_____

What do you wish for your child?

_____

_____

_____

Person providing this information: ____mother ____guardian ____father ____caregiver ____other_____

Date: _____

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