The Children's Hospital of Philadelphia®

PEDIATRIC FEEDING & SWALLOWING CENTER

Feeding History Questionnaire

You must complete this form prior to your child's visit. Please fax or e-mail it back to us at **(215) 590-9338** or Feedingctr@email.chop.edu at least 10 days before your appointment.

Today's date: _______________

Child's name: ______________________________ Date of birth: _________________ Sex: ☐ M ☐ F

Person completing this form: ________________ Relationship to child: ______________________

What concerns do you have about your child's eating?

____

____

____

What do you hope to gain from this appointment?

____

____

____

GENERAL HISTORY

1. Is your child currently allowed to eat by mouth? ☐ Yes ☐ No

   Is your child currently allowed to drink by mouth? ☐ Yes ☐ No

2. Does your child have any of the following symptoms when eating or drinking? (Please check all that apply.)

- ☐ gagging/coughing
- ☐ vomiting
- ☐ eats a limited variety of food/selective
- ☐ slow weight gain
- ☐ refuses to eat
- ☐ spits out food
- ☐ cries/screams
- ☐ other (specify)
- ☐ choking
- ☐ limited volume/not eating enough
- ☐ difficulty swallowing
- ☐ refuses to swallow/holds food in mouth
- ☐ difficulty progressing to table food
- ☐ does not remain seated
- ☐ throws food and/or utensils

____

3. At what age did your child's eating first become a concern? ____________________

4. Has your child been seen by any other specialists/therapists to help with Feeding?

- ☐ Gastroenterology doctor ___________________________
- ☐ Ear, Nose, and Throat doctor ________________________
- ☐ Early Intervention _________________________
- ☐ Dietitian/Nutritionist ______________________
- ☐ Outpatient Therapy ________________________
- ☐ Speech Therapy ___________________________
- ☐ Other Feeding Program ___________________________
- ☐ Alternative medicine provider _______________________
- ☐ Other ____________________________

5. What strategies have you tried to deal with your child's eating problems?

- ☐ distraction during meals (e.g. games, TV)
- ☐ forcing
- ☐ skipping meals
- ☐ allowing child to drink more fluids
- ☐ rewards
- ☐ giving preferred foods
- ☐ feeding child when s/he requests food
- ☐ punishment
- ☐ coaxing
- ☐ high calorie supplements/formula
- ☐ other (specify)

____

Please describe: ____

BIRTH HISTORY

Were there any complications during pregnancy? ☐ Yes ☐ No

If yes, check the ones that apply:

- ☐ Gestational Diabetes
- ☐ Elevated blood pressure
- ☐ Pre-eclampsia
- ☐ Pre-term contractions
- ☐ Meconium aspiration
- ☐ Polyhydramnios (extra amniotic fluid)
- ☐ Other __________

How many weeks into pregnancy (Gestational age) was the baby delivered? : ____________weeks

How was the baby delivered?

- ☐ vaginal
- ☐ vacuum/forceps assist
- ☐ Cesarean - If Cesarean, why? __________

Baby's Birth weight: ______lbs______ oz Birth length: _______inches

Any complications with baby at birth? ☐ Yes ☐ No

If yes, please specify ____

Was the baby in the NICU? ☐ Yes ☐ No

If yes, why?

___

If yes, how long was your baby in the NICU? ___

Was your baby breast fed? ☐ Yes ☐ No
If yes, for how long? ___
If yes, did you have difficulty breastfeeding? ☐ Yes ☐ No
If yes, please explain:
___

Did your baby ever drink formula? ☐ Yes ☐ No
If yes, what brand (s) of formula? ___

If yes, did your child have difficulty bottle feeding? ☐ Yes ☐ No
If yes, please explain:
___

At what age did you start spoon feeding? ___
Did he/she have difficulty? ☐ Yes ☐ No
If yes, please explain:
___

MEDICAL HISTORY

1. Please note any of your child's medical, developmental and/or mental health diagnoses.

☐ GE reflux (heartburn) ☐ failure to thrive/slow growth ☐ developmental delay
☐ esophagitis ☐ pulmonary (lung) issues (asthma) ☐ cardiac (heart) issues
☐ neurologic (brain)issues ☐ slow stomach emptying ☐ constipation
☐ renal (kidney) issues ☐ eosinophilic esophagitis ☐ diarrhea
☐ autism/PDD ☐ G6PD
☐ mental health (specify)___ ___
☐ Genetic/chromosome abnormality (specify) ___
☐ other (specify) ___

2. How often does your child have a bowel movement? ☐ daily ☐ every other day ☐ other
___
Does s/he have issues with: Constipation (hard stools) ☐ Yes ☐ No Diarrhea (loose stools) ☐ Yes ☐ No

3. Is your child allergic to or does he/she react to the following? If yes, please describe the reaction.

☐ Prescription medicines (Reaction: ___)
☐ Over the counter medicines, supplements, or herbal remedies (Reaction: ___)
☐ Foods, food additives, or drink s(Reaction: ___)
☐ Latex or anything else such as bandages or tape (Reaction: ___)
☐ X-ray, CT, MRI, or other radiology dyes (Reaction: ___)

☐ Blood products (Reaction: ____)

☐ None known

PEDIATRIC CARE

1. Does your child currently see any specialists? ☐ Yes ☐ No

If yes, please list below:

Name of Specialist	Specialty	Location	Date last seen

2. Have any of the following medical tests been done?

☐ upper GI series ☐ milk scan ☐ modified barium swallow study

☐ endoscopy ☐ pH probe ☐ genetic (chromosome) testing

☐ head CT scan ☐ head MRI scan ☐ bone age film/x-ray

☐ allergy testing ☐ other (specify) ________________________

Were these tests done at CHOP? ☐ Yes ☐ No If no, please bring the results of these tests with you.

3. Please list your child's current medications. (Please include: vitamins, supplements, herbal remedies and other over-the-counter medications)

Medication	Dose	How often

4. Has your child ever been hospitalized or required surgery? ☐ Yes ☐ No

If yes, please explain and give dates: ____

5. Are your child's immunizations up to date? ☐ Yes ☐ No

6. Are you concerned about your child's weight? ☐ Yes ☐ No

If yes, are you concerned it is ☐ too little or ☐ too much?

FAMILY HISTORY:

Dad's height: _______ft _____in Mom's height: _______ft _____in

Are there medical problems that run in the family? Please check (√) the boxes that apply:

	Cystic fibrosis	Asthma	Thyroid disease	Diabetes	GE reflux (heartburn)	Ulcerative colitis	Irritable bowel	Stomach ulcers	Celiac disease	Crohn's disease	Liver disease	Food allergies	Environmental allergies	Heart disease	Developmental delay	Learning disabilities	Genetic disease	Mental health	Other
Biological mother																			
Biological father																			
Sister																			
Brother																			
Maternal grandmother																			
Maternal grandfather																			
Paternal grandmother																			
Paternal grandfather																			
Other (please specify)																			

Mother's name Age Occupation

____

Father's name Age Occupation

____

Who lives at home with the patient? ____

Names and ages of brothers and sisters? ____

EATING ENVIRONMENT

1. Where does your child usually sit during mealtimes?
   - ☐ infant seat ☐ highchair ☐ booster seat ☐ chair at table
   - ☐ child stands ☐ child wanders around ☐ in front of TV ☐ held in caretaker's arms
   - ☐ on caretaker's lap ☐ other ______________________________
2. Where in the house is your child fed?
   - ☐ kitchen ☐ dining room ☐ living room ☐ walking around
   - ☐ other (please specify) ______________________________
3. With whom does your child usually eat/drink?
   - ☐ alone ☐ with parents ☐ with siblings ☐ with peers ☐ with nurse
4. At what other locations does your child eat/drink?
   - ☐ daycare ☐ school ☐ other relative's home ☐ in the car

HOW DOES YOUR CHILD EAT/DRINK NOW?

1. Who feeds your child?
   - ☐ Mother ☐ Father ☐ Sibling ☐ Grandparent ☐ Nurse
   - ☐ Teacher ☐ Daycare provider ☐ other (please specify) ____________
2. Please note your child's current feeding skills.
   - a. Spoon fed? ☐ Yes ☐ No If yes, type of spoon? ________________
   - b. Child feeds self? ☐ Yes ☐ No
     - Finger feeding: ☐ beginning ☐ partially successful ☐ completely successful
     - Feeds self with spoon: ☐ beginning ☐ partially successful ☐ completely successful
     - Feeds self with fork: ☐ beginning ☐ partially successful ☐ completely successful
   - c. Drinking from breast? ☐ Yes ☐ No
   - d. Drinking from a bottle? ☐ Yes ☐ No
     - If yes, what type of nipple:
     - ☐ regular ☐ orthodontic ☐ other (please specify)________________
     - How is your child positioned during feeding?
     - ☐ seated ☐ held ☐ other (please specify)________________
   - e. When is bottle/breast offered? ______________________________
   - f. Drinking from a cup? ☐ Yes ☐ No If yes, type of cup ________________
   - g. Straw drinking? ☐ Yes ☐ No
3. What does your child drink and how much?
   - ☐ Milk ____________ounces per day (Type of Milk: ________________)
   - ☐ Infant Formula ____________ounces per day (Name of Formula: ________________)

☐ Water ____________________ounces per day
☐ Nutritional Supplement______ ounces per day (Name of Supplement: ________________________)
☐ Juice _____________________ounces per day
☐ Soda/tea ___________ounces per day
☐ Other ___________________________________ounces per day (Specify____________________)

Food Textures

1. Please check (√) your child's current ability to eat a variety of food textures:

Texture	Eats easily	Eats with difficulty	Refuses	Cannot eat	Never tried
Baby food					
Pureed table food					
Mashed table food					
Dissolvables (e.g. puffs, veggie sticks, Cheerios)					
Chopped table food					
Soft table food (e.g. pancakes)					
Crunchy table food (e.g. apple, crackers)					
Difficult to chew table food (e.g. meat)					

2. Please give examples of food your child will eat from all food groups

Food Group	**Examples**
Fruit	________________________________
Vegetables	________________________________
Grains (bread/cereal/ pasta/rice)	________________________________
Meats/egg/peanut butter	________________________________

Dairy (milk/cheese/yogurt) or alternatives (soy/almond milk) ______________________________

TUBE FEEDING ASSESSMENT

1. Does your child receive tube feeds?: ☐ Yes ☐ No (If not, please skip this section)
   If yes, when did you child first start feeding through a tube? ________________________
2. What is the name and specialty of the Provider who tells you what to give through the tube?
   ____
3. Type of tube used: ☐ NG ☐ G ☐ G-J
4. Formula used: ____
5. Schedule: (Include times, amount given and rates) ____

Do you add anything extra such as butter, oil, salad dressing to foods to increase calories?

☐ Yes ☐ No

If Yes, please specify what you add and how much ____

____

DIET ASSESSMENT

Please list everything your child might eat or drink during a typical day.
Describe all food, formula, drinks, snacks, food extras (butter, oil, salad dressing) *that are offered AND the amounts actually eaten.*

Food and how much offered	**Amounts of food and drink child actually eats/drinks**
Example: Stage 2 carrots	4 ounce jar
Example: whole milk with heavy cream	6 ounces + 1 tablespoon
Example: Chewy granola bar	¼ of the bar

Breakfast:	**Amounts of food and drink child actually eats/drinks**

Snack:	**Amounts of food and drink child actually eats/drinks**

Lunch:	**Amounts of food and drink child actually eats/drinks**

Snack:	**Amounts of food and drink child actually eats/drinks**

Dinner:	**Amounts of food and drink child actually eats/drinks**

Bed Time Snack:	**Amounts of food and drink child actually eats/drinks**

DEVELOPMENTAL/ BEHAVIORAL/SOCIAL

Do you have any concerns with your child's development? ☐ Yes ☐ No

If yes, please specify your concerns ____

____

2. Does your child receive any of the following services:

Service	**Yes/No**	**Duration and Frequency** (i.e., 1 hour 3 times per week)	**Who provides these services?**
Occupational therapy	☐Yes ☐No		
Physical therapy	☐Yes ☐No		
Speech therapy	☐Yes ☐No		
Feeding therapy	☐Yes ☐No		
Behavioral therapy	☐Yes ☐No		
Special Instruction/Education	☐Yes ☐No		
Other therapy (Please specify):	☐Yes ☐No		

3. Does your child go to?

☐ Day Care

☐ Medical Day Care

☐ Head Start

☐ School

- ☐ Preschool
- ☐ Kindergarten
- ☐ Grade _____________
- ☐Other ____________________________

4. Please indicate any of the following concerns that you or others who spend time with the child (i.e., teacher, daycare) may have:

- ☐ Irritability/Crankiness
- ☐ Attention Problems
- ☐ Difficulty Following Directions
- ☐ Sleep Difficulties
- ☐ Social Skills Difficulties
- ☐ Anxiety/Worrying
- ☐ Temper Tantrums
- ☐ Hyperactivity

Please describe: ____

Do you have any additional mental health or behavioral concerns? ____
____

Please tell us anything else you think may be important for us to know about your child's feeding.

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