

Feeding & Swallowing Clinic Feeding History Questionnaire

*This form must be completed and submitted before your child can be scheduled with our clinic.*

Today’s Date: Click or tap to enter a date. WV County of Residence: Choose an item.

Child’s Name:       Date of Birth: Click or tap to enter a date.

Sex: Choose an item. Race: Choose an item. Ethnicity: Choose an item.

Address:

City:       State: Choose an item. Zip:

Person Filling out Form:       Email:

 Relationship to Child:       Child lives with: Choose an item.

 Siblings in the home, ages:

 Other adults in the home, and relationship to child:

Primary Contact:       Phone Number:

Secondary Contact:       Phone Number:

Primary Physician:       Physician Number:

Reason for Referral:       Referred by:

When did feeding first become a concern?

My child *primarily* eats by: [ ]  mouth [ ]  feeding tube [ ]  parenteral nutrition/TPN

 [ ]  other,

*My biggest concerns about my child’s eating:*

*My goals for my child’s Feeding Clinic visit:*

BIRTH HISTORY *(complete as thoroughly as possible)*

My child was born: [ ]  full term Via: [ ]  vaginal birth

 [ ]  prematurely/early at       weeks gestation [ ]  cesarean (c-section)

 [ ]  past due date/late at       weeks gestation

Birth weight:       Length at birth:       Born as a multiple: [ ]  Yes [ ]  No

Supplemental oxygen, CPAP, or intubation required at birth? [ ]  Yes [ ]  No

APGAR scores:

Forceps or vacuum assist during birth? [ ]  Yes [ ]  No

Describe any complications during pregnancy:

Medications/drugs taken during pregnancy:

Complications during or right after birth:

As an infant my child, *check all that apply*: [ ]  breastfed [ ]  bottlefed [ ]  was tube fed [ ]  received TPN

My child was in the neonatal intensive care unit (NICU)? [ ]  Yes [ ]  No

 *If yes, for how long?*

*Reason(s) for NICU stay:*

MEDICAL AND DEVELOPMENTAL HISTORY *(complete as thoroughly as possible)*

Medical Diagnoses:

Developmental Delays:

Significant family medical history:

Current medications:

Vitamins or supplements, and dosage(s):

Food allergies? [ ]  Yes [ ]  No *If yes, please list:*

Food intolerances? [ ]  Yes [ ]  No *If yes, please list:*

Medication allergies? [ ]  Yes [ ]  No *If yes, please list:*

My child has experienced: Reflux [ ]  now [ ]  in the past

Frequent colds [ ]  now [ ]  in the past

Ear infections [ ]  now [ ]  in the past

Asthma/Reactive airway disease [ ]  now [ ]  in the past

My child has been diagnosed with aspiration pneumonia: [ ]  Yes [ ]  No

*If yes, when and how many times?*

My child has had a swallow test/modified barium swallow study: [ ]  Yes [ ]  No

*If yes, when and what were the results? (attach report if available*)

Please list other medical tests or procedures, dates completed, and results: *(GI studies, MRIs, genetic testing, CT*

*scans, allergy panels, pH probes, scopes, etc.)*

My child has experienced: Constipation [ ]  now [ ]  in the past

Diarrhea [ ]  now [ ]  in the past

Overweight [ ]  now [ ]  in the past

Underweight [ ]  now [ ]  in the past

Failure to Thrive [ ]  now [ ]  in the past

From my child’s most recent medical appointment on Click or tap to enter a date.

 Weight:

 Height/length:

 Head circumference:

My child has been seen by a dentist: [ ]  Yes [ ]  No

*Please describe any dental concerns:*

Describe your child’s sleep patterns:

My child: [ ]  uses diapers [ ]  is potty training [ ]  is toilet trained [ ]  other,

My child’s favorite play activities/interests:

My child engages in self-injurious behavior: [ ]  Yes [ ]  No

*If yes, please describe:*

My child acts aggressively towards others: [ ]  Yes [ ]  No

*If yes, please describe:*

*My child has been seen by:*

[ ]  Genetics [ ]  Neurology

[ ]  Gastroenterology/GI [ ]  Pulmonology

[ ]  Orthopedics [ ]  Ophthalmology/Optometry *(vision)*

[ ]  Developmental Pediatrician [ ]  Cardiology

[ ]  Psychology [ ]  Neonatology

[ ]  Endocrinology [ ]  Otolaryngology *(ear, nose, & throat)*

[ ]  Audiologist *(hearing)* [ ]  Other specialist(s):

*My child has received the following service(s):*

Birth To Three [ ]  now [ ]  in the past

Individualized Education Plan (IEP) [ ]  now [ ]  in the past

*Current School Setting:* [ ]  *Regular Class*  [ ]  *Special Needs Class* [ ]  *Home-based*

*My child has participated in the following:*

Physical therapy: [ ]  now [ ]  in the past

*Current PT goals:*

Occupational therapy: [ ]  now [ ]  in the past

*Current OT goals:*

Speech therapy: [ ]  now [ ]  in the past

*Current speech goals:*

Feeding therapy: [ ]  now [ ]  in the past

*Provided by:* [ ]  *SLP* [ ]  *OT* [ ]  *Other,*

*Current feeding goals:*

ABA/Behavioral Therapy: [ ]  now [ ]  in the past

*Provided by:* [ ]  *BCBA* [ ]  *Psychologist* [ ]  *Other,*

*Current behavioral goals:*

Mental Health Therapy: [ ]  now [ ]  in the past

*Provided by:* [ ]  *Psychologist* [ ]  *Social Worker* [ ]  *Counselor* [ ]  *Other,*

*Current mental health goals:*

MOBILITY AND GROSS MOTOR SKILLS

My child, *check all that apply*: Holds head up independently? [ ] Yes [ ]  No

 Sits independently? [ ]  Yes [ ]  No

 Stands independently? [ ]  Yes [ ]  No

 *If no, can your child stand with assistance?*  [ ]  *Yes* [ ]  *No*

Walks independently? [ ]  Yes [ ]  No

*If no, can your child walk with assistance?* [ ]  *Yes* [ ]  *No*

My child uses, *check all that apply*:

 [ ]  wheelchair [ ]  walker [ ]  stander [ ]  gait trainer [ ]  ankle, leg, or foot braces

MEALTIMES

My child *most often* eats meals: [ ]  on a caregiver’s lap [ ]  in an infant/bouncy seat

 [ ]  in a highchair [ ]  in a booster seat at the table

 [ ]  in a chair at the table [ ]  in a specialized feeding seat

 [ ]  in a wheelchair [ ]  other,

My child *most often* eats: [ ]  with the family [ ]  separate from family

My child *most often* eats in front of the TV or with an iPad/computer? [ ]  Yes [ ]  No

My child is fed on a consistent schedule? [ ]  Yes [ ]  No

I know my child is hungry when:

I know my child is full when:

My child *most often*: [ ]  Eats independently *or* [ ]  Is fed by,

The average time for my child to complete a meal:

I have tried the following strategies to help my child with eating, *check all that apply:*

 [ ]  bargaining [ ]  coaxing [ ]  providing supplements (such as Pediasure)

 [ ]  forcing [ ]  distractions [ ]  offering only preferred foods

 [ ]  rewards [ ]  punishment [ ]  providing unlimited fluids (such as milk)

 [ ]  skipping meals [ ]  other(s),

During mealtimes, I think my child *most often* feels:

During mealtimes with my child, I *most often* feel:

Does anyone else in the family have similar feeding difficulties? [ ]  Yes [ ]  No

*If yes, please describe:*

SELF FEEDING SKILLS

My child can, *check all that apply*: [ ]  Hold small foods or toys if placed in hand

 [ ]  Pick up small foods or toys using thumb and index finger (pincer grasp)

 [ ]  Hold a spoon

 [ ]  Scoop food using a spoon

 [ ]  Hold a bottle

 [ ]  Hold a cup

 [ ]  Drink from a cup/bottle independently

My child can see and recognize food easily: [ ]  Yes [ ]  No [ ]  I’m not sure

My child eats using, *check all that apply:* [ ]  Hands [ ]  Spoon [ ]  Fork [ ]  Bottle [ ]  Cup

My child uses adaptive feeding equipment: [ ]  Yes [ ]  No

*If yes, please describe:*

TUBE FEEDING

My child uses a feeding tube for some or all nutritional intake: [ ]  Yes [ ]  No

 \*\**If no, please skip to Food Textures and Consistencies section.\*\**

When was feeding tube placed? Click or tap to enter a date.

Why was tube initially placed?

Type of tube: [ ]  G [ ]  G-J [ ]  NG [ ]  Other,

Name/specialty of provider who manages what is given through tube?

Nutrition received through tube? *Check all that apply:*

[ ]  Formula, specific brand/type-

[ ]  Milk, specific brand/type-

[ ]  Juice

[ ]  Water

[ ]  Blenderized foods

[ ]  Other,

Tube feed schedule (volumes, rates, times):

My child has been medically cleared to eat by mouth: [ ]  Yes [ ]  No

*If yes, physician providing medical clearance:*

*If yes, most recent diet order:*

FOOD TEXTURES AND CONSISTENCIES

Mark the box best describing your child’s ability *(easy, difficult, refuses, or never tried)* to eat each food type:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Eats Easily  | Has Difficulty  | Refuses  | Never tried  |
| Stage 1 Baby Food *(thin purées, smooth, no chunks)* |  |  |  |  |
| Stage 2 Baby Food*(thicker purées, no chunks)* |  |  |  |  |
| Stage 3 Baby Food*(purées with small chunks)* |  |  |  |  |
| Puréed table foods |  |  |  |  |
| Mashed table foods  |  |  |  |  |
| Chopped table foods |  |  |  |  |
| Easily dissolved foods*(puffs, veggie straws, yogurt melts)* |  |  |  |  |
| Regular table foods  |  |  |  |  |
| Crunchy foods*(chips, pretzels, apples)* |  |  |  |  |
| Soft/mushy foods*(bread, cooked vegetables, pasta)* |  |  |  |  |
| Foods requiring chewing *(meats, nuts, raw vegetables)* |  |  |  |  |

My child requires thickened liquids: [ ]  Yes [ ]  No

*If yes, please list consistency and precautions:*

My child’s favorite foods:

Does your child only eat very specific brands, colors, or types of foods? [ ]  Yes [ ]  No

*If yes, please list:*

Are there foods your child used to eat, but now refuses? [ ]  Yes [ ]  No

*If yes, please list:*

ORAL MOTOR AND BEHAVIORAL FEEDING SKILLS

My child has difficulty, *check all that apply:*

[ ] drinking from a bottle [ ]  keeping liquid in the mouth

[ ]  transitioning from a bottle to solid foods [ ]  taking food from a spoon or fork

[ ]  keeping food in the mouth [ ]  keeping lips closed while eating

[ ]  moving tongue [ ]  chewing/biting

[ ]  drinking from a cup [ ]  touching food

[ ]  accepting new foods [ ]  staying at the table

Mark the box best describing how often *(always, sometimes, or never)* during meals your child:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Always  | Sometimes  | Never  |
| Coughs |  |  |  |
| Chokes |  |  |  |
| Gags |  |  |  |
| Vomits  |  |  |  |
| Turns away from food/refuses food/not interested in food |  |  |  |
| Spits out food  |  |  |  |
| Eats very small amounts |  |  |  |
| Throws food  |  |  |  |
| Gets upset/cries/tantrums  |  |  |  |
| Eats only very specific/selective foods  |  |  |  |
| Holds food in mouth for long periods  |  |  |  |
| Packs mouth full of food/ overstuffs mouth  |  |  |  |
| Avoids chewing  |  |  |  |
| Gets very tired/fatigued |  |  |  |
| Grinds teeth  |  |  |  |
| Avoids getting messy  |  |  |  |
| Drools |  |  |  |
| Gets extremely messy |  |  |  |
| Eats non-food items *(please list)* |  |  |  |
| Other *(please describe)* |  |  |  |

SERVICES AND SUPPORTS

*My child receives benefits from:*

[ ]  Children with Special Health Care Needs Program

[ ]  WIC (Women, Infants, and Children’s Program)

[ ]  IDD Waiver

[ ]  Medicaid/medical card

[ ]  Private insurance

[ ]  CHIPs (WV Children Health Insurance Program)

[ ]  SSI (Supplemental Social Security)

[ ]  Food Stamps/SNAP

My child’s primary insurance is:

Our family needs extra support with: [ ]  accessing services [ ]  education planning

 [ ]  advocacy [ ]  navigating medical services

 [ ]  transition services [ ]  other,

Describe any recent changes or stresses in the family:

Additional information or questions you would like to share before your visit:

Our family prefers to communicate: [ ]  via phone/standard mail [ ]  via email

Our family has internet access: [ ]  Yes [ ]  No

I understand clinic is student-friendly and may include the participation of graduate clinicians: [ ]  Yes [ ]  No

I understand clinic may be video and/or audio-recorded for educational purposes: [ ]  Yes [ ]  No

*Submit completed form to:*

WVUCED Feeding & Swallowing Clinic

959 Hartman Run Road

Morgantown, WV 26505

*Phone:* (304) 293-4692 x7

*Fax:* (304) 293-7294

*Email:* CEDClinics@hsc.wvu.edu