

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](mailto:CEDClinics@hsc.wvu.edu)