Skills on the Hill
PEDIATRIC OCCUPATIONAL THERAPY

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PEDIATRIC FEEDING HISTORY FORM

Date: _____

Child's Name: _____ Date of Birth: _____

Please explain, in your own words, about your child's current feeding problem:

_____

_____

_____

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? Circle the behaviors shown and describe when they would happen, and 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 was your child introduced to baby cereal? _____ baby foods? _____

Finger foods? _____ Table foods? _____

At what age did your child transition fully to table food? _____

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

_____

_____

_____

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

List the foods that your child currently will eat and drink (put a star next to their favorites): _____

_____

_____

List the foods your child refuses: _____

_____

_____

List the foods your child previously would eat but no longer eats: _____

_____

_____

List the foods your child is allergic to: _____

DESCRIBE YOUR CHILD'S MEALTIME:

Who typically feeds your child? _____

Who typically eats with your child? _____

What type of chair is used? (Please send a photo to your evaluating therapist via email or show the therapist during the evaluation.) _____

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? What activities (describe)? _____

Are there any household rules around mealtimes? What are the expectations for your child during family meals?_____

What times does your child typically eat and what type (bottle, breast, solids)?

Time	Breast	Bottle	Solids (baby food; table?)

Time	Breast	Bottle	Solids (baby food; table?)

IF YOUR CHILD IS *TUBE FED*, PLEASE ANSWER THE FOLLOWING QUESTIONS:

What type of formula is used and exactly how do you mix it? _____

_____

Describe where your child is tube fed and what activities are occurring at the same time: _____

_____

Describe your child's reactions to the tube feedings (connecting, during, disconnecting): _____

_____

Please detail your child's feeding schedule below.

Time of feeding (start time)	NG, G or Continuous	Amount	Gravity or Pump	Over what time period or what rate

*PLEASE ANSWER FOR ALL CHILDREN

Has your child ever been on any type of special diet other than what you just described (circle 1)? **YES NO**

If yes, please describe type of diet, at what ages, why and what was your child's response: _____

_____

How do you know your child is hungry or full?

Hungry? _____

Full? _____

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

Would you describe your child's weight as (circle one): Ideal Underweight Overweight

Does your child have/had any of the following problems (circle which ones)? Dental, frequent constipation,

frequent diarrhea, vomiting, choking, gagging, coughing Please describe: _____

_____

_____

Does your child take a vitamin supplement? Which one? _____

Describe how you and your child feel after a feeding:

You: _____

Your child: _____

What other evaluations have been completed regarding your child's feeding difficulties and what were the results/ what were you told? _____

_____

_____

What treatments have been tried for this problem, and what were the results? _____

_____

MEDICAL HISTORY OF CHILD

It is very important to have as complete a medical history for your child as possible. Please fill out the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	
3			Frequent Ear Infections (?tubes)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Anemia/blood disorder	
9			Kidney/Renal disorder	
10			Urinary problems/infections	
11			Hormonal problem	
12			Muscle disorder/muscle problem	
13			Joint or bone problems	
14			Fractured bones	
15			Skin disorder/skin problems (eczema)	
16			Visual disorder/vision problems	
17			Eye infections	
18			Neurological disorder	

19			Seizures or convulsions	
20			Stomach disorder/stomach pain	
21			Vomiting/digestion problems	
22			Failure to gain weight/feeding problems	
23			Constipation/diarrhea problems	
24			Dehydration episodes	
25			Hearing Loss/Ear disorder	
26			Significant accidents	
27			Head injuries or concussions	
28			Ingestion of toxins, poisons, foreign objects	
29			Major medical procedures (detail below)	
30			Chronic medications (for what? when?)	
31			Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	

HOSPITALIZATIONS AND/OR SURGERIES:

List the dates of any hospitalizations your child has had and the reason. List the dates of any surgeries your child has had and the reasons. _____

_____

_____

PRESENT HEALTH STATUS: Most recent Height = _____ Weight = _____ Date: _____

Please note any illnesses for which your child is currently being treated, including their Current Medications:_____

_____

_____

Has your child ever been in other therapies (eg. Occupational Therapy, Speech Therapy, psychotherapy, Physical Therapy)? Please indicate what type and when, and who the provider was.

Start date – End date	Type of Therapy	Provider Name	Provider contact information