

THE SPEECH & HEARING CLINIC at  
TEXAS WOMAN'S UNIVERSITY  
Department of Communication Sciences & Disorders  
P O Box 425737  
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## FEEDING CASE HISTORY FOR CHILDREN

Please fill in the information as completely as possible.

### I. BACKGROUND INFORMATION

Patient's name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Mother's name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Street City State Zip

Mother's occupation: \_\_\_\_\_ Work phone: \_\_\_\_\_

Father's name: \_\_\_\_\_ Age: \_\_\_\_\_

Address and phone: (if different than mother's) \_\_\_\_\_  
Street City State Zip Phone

Father's occupation: \_\_\_\_\_ Work phone: \_\_\_\_\_

Highest grade completed by mother: \_\_\_\_\_ by father: \_\_\_\_\_

Are parents divorced? \_\_\_\_\_ If so, who has custody of child? \_\_\_\_\_

If child is not living with either biological or adoptive parent, who has legal guardianship?

\_\_\_\_\_ Relation to child: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

If the parent(s) are employed outside of the home, who cares for the child in their absence?

\_\_\_\_\_

Family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

List siblings	Age	Sex	Do they live in the home?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## II. MEDICAL HISTORY

List medical diagnosis your child has been given: \_\_\_\_\_

\_\_\_\_\_

List any surgeries or procedures your child has had performed: \_\_\_\_\_

\_\_\_\_\_

List any medical tests your child has had and any important results (eg. MRI, UGI, VSS, MBS)

\_\_\_\_\_

List any medications (prescription and over-the-counter) your child is taking: \_\_\_\_\_

\_\_\_\_\_

Check disease(s) your child has had, giving age and degree of severity:

<u>Disease</u>	<u>Age</u>	<u>Mild, average or severe</u>	<u>Disease</u>	<u>Age</u>	<u>Mild, average or severe</u>
allergies	_____	_____	kidney disease	_____	_____
asthma	_____	_____	measles	_____	_____
bronchitis	_____	_____	meningitis	_____	_____
chicken pox	_____	_____	mumps	_____	_____
colds (frequent)	_____	_____	ear infections	_____	_____
hay fever	_____	_____	pneumonia	_____	_____
headaches (frequent)	_____	_____	scarlet fever	_____	_____
heart disease	_____	_____	seizures	_____	_____
influenza	_____	_____	tonsillitis	_____	_____

Other illnesses not noted above: \_\_\_\_\_

Describe aftereffects of any illness, if any: \_\_\_\_\_

### III. DEVELOPMENTAL HISTORY

During this pregnancy, did mother experience any unusual illness, condition or accident, such as German Measles, false labor, RH incompatibility, etc? \_\_\_\_\_

If so, describe: \_\_\_\_\_

\_\_\_\_\_

Length of pregnancy: \_\_\_\_\_ Duration of labor: \_\_\_\_\_ Birth weight: \_\_\_\_\_

Normal delivery: \_\_\_\_\_ Caesarean: \_\_\_\_\_ Breech birth: \_\_\_\_\_

Anesthetics: \_\_\_\_\_ Forceps: \_\_\_\_\_ Was infant blue? \_\_\_\_\_ Jaundiced? \_\_\_\_\_

Other concerns: \_\_\_\_\_

Seizures? \_\_\_\_\_ Swallowing or sucking difficulties? \_\_\_\_\_

\_\_\_\_\_

Scars or bruises? \_\_\_\_\_ Was birth weight regained quickly? \_\_\_\_\_

Drugs/Alcohol used during pregnancy? (type and amount) \_\_\_\_\_

At what age did your child:  
hold up his/her head alone? \_\_\_\_\_

first crawl? \_\_\_\_\_

sit alone without support? \_\_\_\_\_

pull himself/herself to a standing position? \_\_\_\_\_

walk unaided? \_\_\_\_\_

say his/her first word? \_\_\_\_\_

gain bowel control? \_\_\_\_\_ frequency of bowel movements \_\_\_\_\_ bladder control? \_\_\_\_\_

Weight of your child at 6 months: \_\_\_\_\_ Weight at present: \_\_\_\_\_

Is your doctor concerned about your child's weight? yes no

Height at present? \_\_\_\_\_ Does your child prefer right or left hand? \_\_\_\_\_

Describe your child's speech: \_\_\_\_\_

Did you or do you have any concern about speech language development? \_\_\_yes \_\_\_no  
If yes please  
describe. \_\_\_\_\_  
\_\_\_\_\_

Does your child seem to understand what is said to him/her? yes no sometimes

How can you tell? \_\_\_\_\_

What language(s) are spoken in the home? \_\_\_\_\_

Which one is the primary language? \_\_\_\_\_

#### IV. SENSORY

Does your child have  
 difficulty with balance?  fear of heights?  being moved unexpectedly?

Are there activities that involve fast movements and spinning that your child finds difficult? \_\_\_\_\_

Does your child seem awkward, uncoordinated? \_\_\_\_\_

Is your child sensitive  to touch?  loud noises? If so, please describe. \_\_\_\_\_  
\_\_\_\_\_

Does your child dislike any of the following?  
bathing walking barefoot clothing getting messy

Describe any developmental difficulties: \_\_\_\_\_  
\_\_\_\_\_

Describe any academic difficulties: (reading, math, writing, spelling) \_\_\_\_\_  
\_\_\_\_\_

Does your child exhibit any sleep difficulties? If so, please describe: \_\_\_\_\_  
\_\_\_\_\_

#### V. FEEDING HISTORY

Does your child have a feeding tube? \_\_\_\_\_ Ng Gtube G button

Amount and frequency of tube feeding? \_\_\_\_\_

What kind of formula is used in the tube feeding? \_\_\_\_\_

Does your child eat by mouth?    yes    no

Amount and type of liquid taken:

by mouth \_\_\_\_\_    breast \_\_\_\_\_    supplemental nursing system \_\_\_\_\_

Does your child use a bottle? (nipple type) \_\_\_\_\_ open cup \_\_\_\_\_

straw \_\_\_\_\_    spoon \_\_\_\_\_

sippy cup (free flow or no-spill; shape of spout) \_\_\_\_\_

How often? \_\_\_\_\_

Do you add a thickening agent to the liquid?    yes    no

If so, what type? \_\_\_\_\_    how much? \_\_\_\_\_

Which of the following food(s) does your child eat?    puree    crunchy snacks

finger foods    soft chopped fruits/veggies    ground meat    most table foods

mixed consistencies (vegetable soup, spaghetti, etc...)

How often? \_\_\_\_\_    In what amounts? \_\_\_\_\_

Does your child self-feed?    yes    no

Does your child have difficulty chewing or swallowing?    yes    no    If so, please describe:

\_\_\_\_\_

Does your child have difficulty eating foods with texture?    yes    no    If so, please describe:

\_\_\_\_\_

What foods does your child prefer? \_\_\_\_\_

List any food(s) that your child refuses to eat (if any)? \_\_\_\_\_

Does your child exhibit any of the following during or after meals?

cough/choke    wet gurgly voice quality    wet breathing    gagging    arching

pulling or turning away    eating/drinking a small amount then refusing any more    crying

Has your child had a Modified Barium Swallow study?    yes    no    If so, when? \_\_\_\_\_

Results and recommendations? \_\_\_\_\_

\_\_\_\_\_

Has your child had previous feeding therapy?    yes    no

If so, what was recommended? \_\_\_\_\_

Did you find it helpful?    yes    no

Describe a typical mealtime with your child: \_\_\_\_\_

\_\_\_\_\_

What do you find most enjoyable? \_\_\_\_\_

What do you find most frustrating? \_\_\_\_\_

What are your goals for your child regarding feeding? \_\_\_\_\_

\_\_\_\_\_

## **VI. Social History**

Describe how your child's feeding issues affect your family: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If there is any additional information about your child that would be helpful for us to know, please list below.

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

Thank you for your interest in our Speech Therapy Program at Texas Woman's University.

If you have any questions, please call Dr. Erica Armstrong at (940) 898-2474. Please return this case history to the following address or fax # to my attention.

Texas Woman's University  
Dr. Erika Armstrong  
P O Box 425737  
Denton, TX 76204-5737

Fax# (940) 898-2070

I look forward to hearing from you.