THE SPEECH & HEARING CLINIC at
TEXAS WOMAN'S UNIVERSITY
Department of Communication Sciences & Disorders
P O Box 425737
Denton, TX 76204-5737
Phone: 940-898-2285 Fax: 940-898-2070

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:

Disease	Age	Mild, average or severe	Disease	Age	Mild, average or severe
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, spaghettios, 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 Kimberly Mory at (940) 898-2024. Please return this case history to the following address or fax # to my attention.

Texas Woman's University
Kimberly Mory
P O Box 425737
Denton, TX 76204-5737

Fax# (940) 898-2070

We look forward to hearing from you.