PERTINENT HISTORY QUESTIONNAIRE

Today's Date: _______________

Name of Child: ________________________ Date of Birth: ___________
Age: ___

Home Address:

____

Street City State Zip

Ethnicity: ___________________________
Language Spoken in Home: __________

Primary Phone:

____

Caregiver(s):

Name: __________________________

Daytime Phone: ___________________

Relationship: Mother Father Other: _____________________

Email Address:

____

Occupation:

____

Name: __________________________

Daytime Phone: ___________________

Relationship: Mother Father Other: _____________________

Email Address:

____

Occupation:

____

Which caregiver completed this form? ___________________________

Emergency Contact & Phone:

____

____

Who referred you to Building Bridges Therapy Center?

____

Home/Family Environment:

Marital Status:

Not Married   Married   Separated   Divorced   Other

All persons living in the home:

Name	Age	Relation to patient	Highest grade completed

PARENTAL CONCERNS

Please describe the major concerns you have in seeking help for your child.

How can this facility help you most with these concerns?

MEDICAL HISTORY

Child's Pediatrician/Family Doctor:

____

Address:

____

Street   City   State   Zip

Please list any other medical doctors or clinics that have examined this child:

Name: Address: Purpose of Examination

____

____

____

Date of Last Medical Checkup: _____________
Height: ___________
Weight: ___________

Has your child been seen by a dietician/nutritionist? Y / N
Are they currently under the care of a dietician/nutritionist? Y / N
Dietician/Nutritionist Name: _________________________________
Address:

____
Street City

____
State Zip

Has your child been diagnosed with any of the following?

Attention Deficit Hyperactive Disorder (specify): ______________________	Dyslexia
	Emotional Disorder
	Fragile X Syndrome
Anxiety of Mood Disorder (specify): ______________________	Learning Disability (specify): ______________________
	Sensory Processing Disorder
Autism Spectrum Disorder	Tourette's Syndrome
Cognitive Delay	Other (specify): ______________________
Down Syndrome	

Have any of the following medical tests been done?

Upper GI series	Head MRI Scan
Endoscopy	Modified Barium Swallow Study
Head CT Scan	Genetic (Chromosome) Testing
Allergy Testing	Bone Age Film/X-ray
Milk Scan	Other (specify): _________________________
pH Probe	

Has child ever had the following:

Eye or vision problems	Ear/Hearing problems
Food Allergies	Seasonal Allergies
Asthma	Meningitis
Convulsions or seizures	Head Injury

Other health problems not listed above (describe)?

Does child take medication on a regular basis? Y / N

If yes, please list medication taken and amount:

Has the child ever been hospitalized? Y / N

Hospital	Year	Reason

PREGNANCY AND BIRTH

While pregnant did child's mother have any of the following:

German Measles	High fever
Emotional Difficulties	Kidney problems
Anemia(low iron)	Smoke cigarettes
Vaginal infection/bleeding	Drink alcohol
Diabetes	Other:
High blood pressure	______________________

Were any medications taken during pregnancy? (include vitamins and iron)

Was the child born: early late on time

Was child born by C-section? Y / N

If yes, please give reason for C-section:

Approximately how long was mother in labor? _______ hours

What was baby's birth weight? __________ length?_________

Apgar Score?_______

What was baby's condition at birth?

ADOPTION

Describe the circumstances surrounding the adoption:

DEVELOPMENTAL AND SCHOOL HISTORY

Please provide a specific age or age range for the following:

At what age did child first:

Sit alone:	___________
Feed self finger foods:	___________
Crawl:	___________
Speak first words:	___________
Stand alone:	___________
Put 2-3 words together:	___________
Walk:	___________
Become toilet trained:	___________

Is child currently enrolled in a school program? Y / N

If yes, please answer the following:

Name of School:

____

Grade: ________ Type of Classroom: _______________________

Has child ever been evaluated by a school diagnostic team? Y / N

If yes, when was evaluation completed and what were the results?

Please describe the child's performance at school. What subjects does he/she do well in? What subjects are more difficult?

Does child receive any special services at school? If yes, please describe:

Is your child receiving feeding therapy in school? Y / N

What are the presenting problems of your child (if being seen for other areas than just eating):
Academic: ____________________
Activities of daily life (e.g., Eating, dressing): ____________________
Relationships: ____________________
Sensory: ____________________
Motor: ____________________
Play: ____________________
Other: ____________________

SOCIAL–EMOTIONAL DEVELOPMENT

What does your child like to do to occupy their time?

Does your child exhibit behaviors at home or at school that concern you (describe)?

What methods are used to discipline child?

Is there anything else you would like for us to know about your child that was not covered above?

FEEDING QUESTIONNAIRE

Please explain, in your own words, what your child’s current feeding problem is:

At what age did your child’s feeding problem first become a concern?________

Was your child breast fed? Y / N From age to age__________
Was your child bottle fed? Y / N From age to age___________

Please describe your child’s initial experience 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?

Arch	Spit Up	Cough	Pull off the nipple
Cry	Gag	Vomit	

Describe when they would happen, 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 weaned off of bottle/breast? _____________

How long did your child receive breast milk? _______________

At what age was your child introduced to:

Baby cereal? ________ Finger foods? _________

Baby food? _________ Table food? __________

When did they transition fully to table food? _____________

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

Please select how your child eats the named texture.

Baby food	easily	with difficulty	refuses	cannot eat	never tried
Puree table food	easily	with difficulty	refuses	cannot eat	never tried
Mashed table food	easily	with difficulty	refuses	cannot eat	never tried
Soft finger solids	easily	with difficulty	refuses	cannot eat	never tried
Chopped table foods	easily	with difficulty	refuses	cannot eat	never tried
Soft table food	easily	with difficulty	refuses	cannot eat	never tried
Crunchy table food (e.g. apples, crackers)	easily	with difficulty	refuses	cannot eat	never tried
Difficult to chew food (e.g. meat)	easily	with difficulty	refuses	cannot eat	never tried

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

List the foods that cause your child to have a meltdown (unable to function with food present):

List the foods your child is allergic to:

Describe your child's mealtime:

Where does your child typically sit during mealtimes? (type of seat and location)

____

Who typically feeds your child?

____

Who typically eats with your child?

____

How long is an average meal?

____

At what age did your child start to use utensils? Do they use any special type of eating tools? (cups, bowls, utensils)

Are there any other activities going on at meals? What activities (describe)?

Please note your child's current feeding skills (select all that apply):

Spoon Fed	Type of Spoon:______________
Bottle	Type of Bottle: ______________
	Nipple Type: _______________
Drinking from a cup	Type of cup: ________________
Straw Drinking	

If your child self feeds, Select all that apply:

Finger feeding   Spoon/fork feeding   Bottle feeding

How is child positioned while eating? ___________________________

Type of chair used: ___________________________________

What types of liquid does your child drink?______________________________

How much liquid does your child drink per day?

___0-8 oz	___8-16 oz	___16-24 oz	___24-32 oz	___32-40 oz	___>40 oz

What times does your child typically eat and what type?

Morning	Noon	Night
Breast	Breast	Breast
Bottle	Bottle	Bottle
Solids	Solids	Solids

Does your child do any of the following during a mealtime?

Refuses to eat	Cries/Screams	Gag/coughs
Spits out food	Vomits	Throws food/utensils
Tries to get out of seat	Holds food in mouth	
	Falls asleep	

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

Type of tube used: NG G G-J

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

____

What is name and specialty of provider who tells you what to give through the tube?

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

Describe your child’s reactions/affect to the tube feedings (connecting, during, disconnecting):

Please detail your child’s feeding schedule below(please include times and amount given).

PLEASE ANSWER FOR ALL CHILDREN

Has your child ever been on any type of special diet other than what you just described? Y / N

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:

Ideal Underweight Overweight

Does your child have/had any of the following problems?

Dental
Frequent constipation
Frequent diarrhea
Vomiting
Choking
Gagging
Coughing

Please describe:

Does your child take a vitamin supplement? Y / N 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?

What strategies have you tried to deal with your child's eating problems? (select all that apply)

Distraction during meals (games, videos)
Skipping meals
Rewards
Feeding child when they request food
Forcing
Coaxing
Allowing child to drink more fluids
Giving preferred foods
Punishment
High calorie supplements/formula
Other (specify):
____
____

Does your child have any physical pain while (associated with) eating or drinking? Y / N

None			Mild				Moderate			Severe
0	1	2	3	4	5	6	7	8	9	10

How often does your child have a bowel movement?

daily every other day other

Does s/he have issues with :

Constipation(hard stools)? Y / N

Diarrhea (loose stools)? Y / N