INFANT FEEDING 0-6 MONTHS
PERTINENT HISTORY QUESTIONNAIRE

Today's Date: _____

Name of infant: _____ 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? _____

<u>Emergency Contact & Phone:</u>

_____

_____

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 infant.

How can this facility help you most with these concerns?

MEDICAL HISTORY

Infant's Pediatrician/Family Doctor:

_____

Address:

_____

Street City State Zip

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

Name:	Address:	Purpose of Examination

Date of Last Medical Checkup: _____
Height: _____
Weight: _____

Has your infant been seen by a Lactation Consultant or breastfeeding specialist?
☐ Y / ☐ N
Are they currently under the care of? ☐ Y / ☐ N

Breastfeeding/Lactation Consultant:
Name: _____
Address:
_____
Street City
_____
State Zip

Does your infant have a diagnosis from a treating physician?
_____

Has your infant had any medical tests done?
_____

Does infant take medication on a regular basis? ☐ Y / ☐ N

If yes, please list medication taken and amount:

Has the infant ever been hospitalized? ☐ Y / ☐ N

Hospital	Year	Reason

PREGNANCY

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

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

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

BIRTH

Was the infant born: ☐ early ☐ late ☐ on time

Was infant 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:

FEEDING QUESTIONNAIRE

Please explain, in your own words, what your infant's current feeding problem is:

At what age did your infant's feeding problem first become a concern?_____

Are you breast or bottle feeding, or both? _____

Please describe your infant's initial experience on the breast and/or bottle:

Does your infant 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 infant was weaned:

At what age was your infant weaned off of bottle/breast? _____

How long did your infant receive breast milk? _____

At what age was your infant introduced to Baby cereal? _____

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

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

Please select how your infant eats the named texture.

Baby cereal	easily ☐	with difficulty ☐	refuses ☐	cannot eat ☐	never tried ☐
Baby food	easily ☐	with difficulty ☐	refuses ☐	cannot eat ☐	never tried ☐
Puree table food	easily ☐	with difficulty ☐	refuses ☐	cannot eat ☐	never tried ☐

Who typically feeds your infant? _____

How long is a feeding? _____

How is your infant positioned while eating? _____

How much liquid does your infant drink per day?

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

What times does your infant typically eat and what type?

☐ Morning
- ☐ Breast
- ☐ Bottle
- ☐ Solids

☐ Noon
- ☐ Breast
- ☐ Bottle
- ☐ Solids

☐ Night
- ☐ Breast
- ☐ Bottle
- ☐ Solids

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

☐ Refuses to eat ☐ Cries/Screams ☐ Falls asleep
☐ Spits out food ☐ Vomits ☐ Gag/coughs

IF YOUR INFANT 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 infant is tube fed in and what activities are occurring at the same time:

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

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

PLEASE ANSWER FOR ALL

How do you know your infant is hungry or full?

Hungry? _____

Full? _____

Has your infant lost or gained any weight?

_____

Would you describe your infant's weight as:

☐ Ideal ☐ Underweight ☐ Overweight

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

☐ Frequent constipation ☐ Choking
☐ Frequent diarrhea ☐ Gagging
☐ Vomiting ☐ Coughing

Please describe:

Does your infant take a vitamin supplement? Y / N Which one?

_____

Describe how you, and your infant feel after a feeding:

You: _____

Your infant: _____

What other evaluations have been completed regarding your infant'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?

Does your infant 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 infant 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