ADVANCED
THERAPY SOLUTIONS

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PEDIATRIC FEEDING/SWALLOWING HISTORY

Today's Date: _____

Person Completing This Form: _____Relationship to Patient: _____

Child

Name:_____ □ Male □ Female

Date of Birth: _____

Age: _____

Home Address: _____

City, State Zip: _____

Phone: _____

E-mail: _____

Referred by: _____

Parent(s) / Guardian(s)

Mother: _____ Occupation: _____ Day Phone:_____

Address (if different from above):_____

Father: _____ Occupation: _____ Day Phone:_____

Address (if different from above):_____

Other People in the Household:

Name _____Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Insurance:

Primary Insurance	
Insurance Carrier:	Contract Number:
Name on Card:	Group Number:
Date of Birth:	SS#:

Secondary Insurance	
Insurance Carrier:	Contract Number:
Name on Card:	Group Number:
Date of Birth:	SS#:

Please check the appropriate box below:
I, the undersigned, □certify ☐do NOT certify that I (or my dependent) have insurance coverage with the entity(s) listed above and assign directly to **Advanced Therapy Solutions, LLC** all benefits from the above entity, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Advanced Therapy Solutions, LLC** to release all information necessary to secure the payment of benefits.

A. GENERAL HISTORY

What concerns do you have about your child's eating that you would like to address?

_____
_____
_____

1. Does your child have any of the following symptoms when eating or drinking? (Check all that apply)

□ Gagging
□ Coughing
□ Choking
□ Vomiting
□ Eats a limited variety of food/selective
□ Slow weight gain
□ Refuses to eat
□ Limited volume/not eating enough
□ Difficulty swallowing
□ Refuses to swallow/holds food in mouth
□ Spits food out
□ Trouble chewing
□ Difficulty progressing to table food
□Other (specify)_____

2. At what age did your child's eating become a concern? _____

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

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

4. Does your child have any physical pain while/associated with eating or drinking?
□ Yes □ No

If YES, please circle your child's usual level of pain/discomfort with eating or drinking on the scale:

None Mild Moderate Severe

0 1 2 3 4 5 6 7 8 9 10

B. BIRTH HISTORY

1. Was your baby born within 2 weeks of his/her due date?
□ Yes □ No
If not, at how many weeks gestation was the baby born? _____

2. How much did your baby weigh at birth? _____
Born by: □ Vaginal □ Caesarian section

3. Did you have any of the following problems with pregnancy, labor, or delivery:

□ Gestational diabetes
□ Abnormal ultrasound
□ Preterm labor
□ Infection
□ Eclampsia/pre-.-eclampsia
□ Other (specify):_____

4. Did your baby have any of the following problems in the hospital (nursery):

□ Gastroesophageal reflux (GER)
□ Apnea
□ Feeding and growth issues
□ Mechanical ventilation
□ Intraventricular hemorrhage (brain bleed)
□ CPAP therapy
□Tube feedings
□ Bronchopulmonary dysplasia (BPD)
□Necrotizing enterocolitis (NEC)
□ Other (specify):_____

5. How long was your baby hospitalized after birth? _____

C. MEDICAL HISTORY

1. Please check any of your child's medical, developmental, and/or mental health diagnoses:

□ GE reflux
□ Esophagitis
□ Neurologic (brain) issues
□Renal (kidney) issues
□Autism/PDD
□ Failure to thrive/slow growth
□ Pulmonary (lung) issues (asthma)
□ Developmental delay
□ Cardiac (heart) issues
□ Constipation
□ Diarrhea
□ Mental health (specify):_____
□ Genetic/chromosome abnormality (specify):_____
□ Slow stomach emptying
□ Toxin exposure in utero (drugs, alcohol)
Other (specify):_____

2. How often does your child have a bowel movement?

□ Daily
□ Every other day
□ Other (specify):_____

3. Does your child have any allergies? □ Yes □ No

□ Food _____
□ Medication _____
□ Contact _____
□ Contrast dyes_____
□ Seasonal/environmental_____
□ Adhesives/tape_____

4. Has your child experienced ear infections? □ Yes □ No

Approximately how often (check one)? □ Rarely □ Occasionally □ Frequently

Has your child's hearing ever been tested? □ Yes □ No / Results _____

Do you feel your child hears normally? □ Yes □ No / Explain _____

D. PEDIATRIC CARE

1. Does your child currently see any specialists? □ Yes □ No

Name of Specialist	**Specialty**	**Location**	**Date last seen**

2. Does your child see a dietician/nutritionist? □ Yes □ No

3. Have any of the following medical tests been done?

□ Upper GI Series
□ Endoscopy
□ Head CT scan
□ Allergy testing
□ Milk scan
□ pH probe
□ Head MRI scan
□ Modified barium swallow study
□ Genetic (chromosome) testing
□ Neuropsychological testing
□ Other (specify):_____

4. Please list your child's current medications (including vitamins, over-the-counter medications):

Medication	**Dose**	**How Often**

5. Has your child ever been hospitalized or required surgery? □ Yes □ No
If yes, please explain and give dates: _____
_____
_____
_____

6. Are your child's immunizations up to date? □ Yes □ No

7. What was your child's weight at his/her most recent doctor visit? _____

E. FAMILY HISTORY

Are there any medical problems that run in the family (parents, siblings, grandparents)?

□ Cystic fibrosis
□ Lung disease
□ Stomach ulcers
□ Thyroid disease
□ Developmental delay
□ Diabetes
□ Drug/alcohol use/abuse
□ Celiac sprue disease
□ Crohn's disease
□ Liver disease/cirrhosis
□ Allergies
□ Learning disabilities
□ Heart Disease
□ Ulcerative colitis
□ GE reflux
□ Spastic colon/irritable bowel
□ Asthma
□ Genetic abnormalities
□ Mental health
□ Other (specify): _____

F. FEEDING HISTORY

1. How was your child fed as an infant?
□ Breast □ Bottle

2. How long did your child receive breast milk? _____

3. Did your child have any difficulties with breast feeding or bottle feeding?
□ Yes □ No
If yes, please describe _____

4. How many infant formulas did you use? _____
Please list: _____

5. Did your child ever take a pacifier? □ Yes □ No

6. At what age did your child eat baby food from a spoon? _____
Did he/she have difficulty? □ Yes □ No
-If yes, please explain: _____

7. Does your child have any teeth? □ Yes □ No
If so, how many? _____
a. Does your child tolerate toothbrushing? □ Yes □ No

G. EATING ENVIRONMENT

1. Where does your child usually sit during mealtimes?

□ Infant seat
□ Child stands
□ On caretakers' lap
□ Highchair
□ Child wanders around
□ Booster seat
□ In front of TV
□ Chair at table
□ Held in caretaker's arms
□ Other : _____

2. Where in the house is your child fed?

□ Kitchen
□ Dining room
□ Living room
□ Walking around
□ Other (specify): _____

3. With whom does your child usually eat/drink?

□ Alone
□ With parents
□ With siblings
□ With peers
□ With nurse

4. At what other locations does your child eat/drink?
□ Daycare

□ School
□ Other relative's home □ In the car

5. Does your child do any of the following during mealtime?

□ Refuse to eat
□ Spits out food
□ Cries/screams
□ Vomits
□ Falls asleep
□ Gags/coughs
□ Holds food in mouth
□ Throws food/utensils
□ Tries to get out of seat

H. CURRENT FEEDING/DRINKING SKILLS

1. Who feeds your child?

□ Mother
□ Father
□ Sibling
□ Grandparent
□ Nurse
□ Teacher
□ Daycare provider
□ Other
(specify):_____

2. Please note your child's current feeding skills:

a. Spoon fed? □ Yes □ No
If yes, type of spoon: _____

b. Child feeds self? □ Yes □ No

Finger feeding: □ beginning □ partially successful □ completely successful

Feeds self with spoon:□ beginning □ partially successful □ completely successful

c. Drinking from breast?
□ Yes □ No

d. Drinking from a bottle? □ Yes □ No

If yes, what type of nipple:

□ regular
□ orthodontic
□ other (specify):
_____
□ slow
□ medium
□ fast

e. Holds own bottle? □ Yes □ No

f. How is your child positioned during feeding?

□ seated
□ held
□ other (specify): _____

g. When is the bottle/breast offered? _____

h. Drinking from a cup? □ Yes □ No
If yes, type of cup:_____

i. Straw drinking? □ Yes □ No

3. What types of liquid does your child drink? _____

4. 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

Food Textures
1. Please check (√) your child's current ability to eat a variety of food textures:

Texture	**Eats easily**	**Eats with difficulty**	**Refuses**	**Cannot eat**	**Never tried**
Baby food					
Puree table food					
Mashed table food					
Soft finger solids					
Chopped table food					
Soft table food (e.g. pancakes)					
Crunchy table food (e.g. apples, crackers)					
Difficult to chew table food (e.g. meat)					

2. Please give examples of food your child will eat from all food groups:

Food Groups:
Fruits _____
Grains (bread/cereal/pasta/rice) _____
Vegetables _____
Dairy (milk/cheese/yogurt) _____
Meats/egg/peanut butter_____

1. Does your child prefer foods that are:
□Room temp □Hot □Cold

I. Tube Feeding Assessment

1. Does your child receive tube feeds: □ Yes □ No (If not, please skip this section)

2. What is the name and specialty of the Provider who tells you what to give through the tube? _____

3. Type of tube used:
□NG
□G
□G-J

4. Formula used: _____

5. Tube feeding Schedule: (Include times and amount given) _____

J. DIET ASSESSMENT

Please list everything your child might eat or drink during a typical day. Describe all food, formula, drinks, snacks, food extras (butter, oil, salad dressing) and the amounts consumed.

Example: Stage 2 carrots	4 ounce jar
Example: whole milk with heavy cream	6 ounces + 1 tablespoon
Example: Chewy granola bar	¼ of the bar

Breakfast:	**Amounts of food and drink child actually eats/drinks**

Lunch:	**Amounts of food and drink child actually eats/drinks**

Snack:	**Amounts of food and drink child actually eats/drinks**

Dinner:	**Amounts of food and drink child actually eats/drinks**

K. BEHAVIOR

1. Please indicate any of the following concerns that you or others who spend time with the child (i.e. teacher, daycare) may have:

□ Has difficulty transitioning between activities
□ Is easily upset
□ Is easily distracted
□ Does not like to be touched
□ Has a high activity level
□ Has difficulty calming down when upset
□ Is irritable or cranky
□ Other (describe): _____

2. What else do you think we should know about your child (e.g., hobbies, interests, social skills)? _____

- Favorite toys/books/movies/shows: _____

3. What are a few specific goals or skills you would like your child to attain in regards to eating?

_____

*Would you like to receive a courtesy reminder for every scheduled appointment? (circle) ***Yes*** *or* ***No***

-If yes, what type of reminder would you like? ***E-mail*** ***Text*** ***Call***

Please provide the phone number or e-mail address where you would like to receive reminders:

_____

Thank you for taking the time to complete this information about your child!

_____ _____

Signature of Parent or Guardian Date