

Georgetown University Hospital Pediatric Feeding and Swallowing Evaluation



Pediatric Feeding History Questionnaire

This form has important questions that help the therapists understand your child. Please fill in all areas that you can. ***Please bring any medical reports you have for our records.***

Completed by (Name/relationship to patient): _____ Date: _____

Child's Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____

Main language used at home: _____ **Other languages used:** _____

Email: _____ **Secondary Email:** _____

Preferred Daytime Phone Number: (____) _____ **Additional Phone Number:** _____

Why are you coming for an evaluation? What are your main concerns?

Has your child been previously evaluated or treated by an occupational therapist, physical therapist, or speech language pathologist? Date(s) of Evaluation(s)?

Please indicate any known adverse/allergic drug and/or food allergies (e.g., penicillin, latex, gluten):

Family History

Please indicate who lives at home and/or cares for your child:

Name	Relationship to Child (parent, sibling, nanny)	Contact Numbers	Medical Diagnoses	Occupation
		Home: _____ Cell: _____		
		Home: _____ Cell: _____		
		Home: _____ Cell: _____		
		Home: _____ Cell: _____		
		Home: _____ Cell: _____		

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Family Medical History

- Biological Child Adoption Foster care Surrogacy

Age at adoption/foster care placement: _____

Additional Information: _____

Pregnancy

Complications: _____

Medications taken during pregnancy: _____

Prenatal exposure to alcohol tobacco drugs other: _____

Maternal hospitalizations: because of _____

From _____ weeks gestation to _____ weeks gestation.

Breech Position

Other: _____

Birth

Name of Hospital: _____ Length of Stay: _____

Full Term Premature Post mature _____ Born at weeks gestation age

Vaginal birth C-section Reason: _____

Difficult Labor _____ Other: _____

Birth Weight: _____ Apgar Scores: _____

Complications: _____

Neonatal:

NICU Stay Hospital: _____ Length of Stay: _____

Ventilator/Breathing Tube

Difficulty Feeding

Oxygen Tube

Physical Therapy

Retinopathy of Prematurity

Occupational Therapy

Seizures

Speech Therapy

Intraventricular Hemorrhage (IVH) Grade _____

Reflux/Gastroesophageal Reflux Disease (GERD)

Periventricular Leukomalacia (PVL)

Additional Diagnoses: _____

Hearing Screening Results: Pass Fail

Vision Screening Results: Pass Fail

Current Medical Status

Please tell us all **other doctors or specialists** involved in your child's care:

Specialty of Physician (ENT, GI, Geneticist)	Name of Physician (First and Last)	Date Last Seen	Phone Number(s)	Fax Number
Pediatrician				

Please list all **medical diagnoses** your child has:

Diagnosis	Age at time of Diagnosis	Diagnosing Physician

Please list all **medications** your child takes:

Medication	Dosage	Route (Oral, Nasal)	Frequency	Prescribing Physician	Start Date	Stop Date

Does your child wear glasses or have problems seeing? _____ (Please describe)

Results of last **hearing** evaluation: _____ Date: _____

Results of last **vision** evaluation: _____ Date: _____

Please list any additional special tests, procedures, and/or hospitalizations/surgical since birth (MRI, EEG):

Date	Procedure	Reason for Testing	Results of Procedure

Development

Please write the age when your child first performed the following skills (circle months or years)

Sat alone: _____ (Months/Years)	Toilet-trained: _____ (Months/Years)
Crawled: _____ (Months/Years)	Learned to Write: _____ (Months/Years)
Walked: _____ (Months/Years)	Said a single word: _____ (Months/Years)
Babbled: _____ (Months/Years)	Dressed Self: _____ (Months/Years)
Used a cup: _____ (Months/Years)	Fed self: _____ (Months/Years)
Pulled to stand: _____ (Months/Years)	Used cup: _____ (Months/Years)

Does your child use any of the following at home or at school?

- Walker Wheelchair Special cups/spoons Pacifier Sippy cup
 Assistive Technology Infant "walker" or jumper Infant Swing Exersaucer
 Other: _____

Speech and Language

Please list any speech/language difficulties: _____

Have your child's language skills regressed? (Lost words, no longer follows directions)

Does your child repeat or echo certain words or phrases? _____

Feeding

How does your child currently receive nutrition? Check all that apply:

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> NG-Tube | <input type="checkbox"/> NJ-Tube |
| <input type="checkbox"/> Bottle: Brand (e.g., Dr. Brown, Avent) _____ | <input type="checkbox"/> G-Tube |
| Nipple type (e.g., fast, level 1): _____ | <input type="checkbox"/> Sippy Cup |
| <input type="checkbox"/> Open Cup | <input type="checkbox"/> Spoon/Fork |
| <input type="checkbox"/> Straw | <input type="checkbox"/> Hands |

If your child receives tube feedings, please complete the following:

- | | |
|--|--|
| <input type="checkbox"/> Continuous Feeds: | _____ cc/hour for _____ hours |
| | Beginning time: _____ Ending Time: _____ |
| <input type="checkbox"/> Bolus Feeds: | _____ cc/oz |
| | Times Given: _____ |

What foods does your child currently take?

- | | |
|--|---|
| <input type="checkbox"/> Breast Milk | <input type="checkbox"/> Pureed Table Foods |
| <input type="checkbox"/> Formula: _____ | <input type="checkbox"/> Soft Chewables |
| Calories (e.g., 28 kcal): _____ | <input type="checkbox"/> Pediasure |
| <input type="checkbox"/> Stage 1 Baby Food | <input type="checkbox"/> Hard Chewables |
| <input type="checkbox"/> Stage 2 Baby Food | <input type="checkbox"/> Chewy foods |
| <input type="checkbox"/> Stage 3 Baby Food | |

List your child's preferred foods/liquids: _____

List your child's non-preferred foods/liquids: _____

How long does a meal (or for infants, a bottle) usually take (e.g., 5 minutes, 1 hour)? _____

Please indicate any known adverse/allergic drug and/or food allergies (e.g., penicillin, latex, gluten):

Does your child display any of the following behaviors related to feeding?

- Frequent coughing/choking related to feeding

- Gagging/vomiting related to feeding
- Refusal behaviors (e.g. head turning) related to feeding
- Difficulty accepting foods of certain textures
- Difficulty chewing
- Holding food in mouth
- Other (please describe any difficulties related to feeding/swallowing):

Has your child had a swallow study by a speech pathologist? Yes No

If yes: Where: _____ When: _____

Results: _____

School or Early Intervention

School or Service: _____ City/County _____

Grade: _____ Teacher(s): _____

Support Services: _____ Approximate # of Students in Class: _____

Individual Family Service Plan (IFSP) Occupational therapy

Individual Education Plan (IEP) Assistive technology

Adapted PE Speech therapy

Physical therapy Classroom aide

Other: _____

Involved in organized activities or sports? _____

Any concerns or difficulties? _____

Behavior

What are your child's favorite activities? _____

What motivates your child? _____

How does child play with brothers and sisters? Poor Fair Well N/A

How does child play with children his/her own age? Poor Fair Well

What is the length of time your child can attend to an activity? _____

Does your child have any behavior issues? _____

Does your child have any attention difficulties? _____

How many hours per night does your child sleep? typically 9pm -7am

Does your child have difficulty falling asleep? Yes No

On average, how many times does your child wake up during the night? _____

Does your child self-feed? Finger Utensils Other _____

Does your child have any repetitive behaviors? (Hand flapping, rocking, lining up toys)

Is your child bothered by certain sensations / feelings?

Noises Textures, clothing, or touch Movements Lights

Please Specify: _____

Please add any other additional information you would like us to know about your child:

THIS QUESTIONNAIRE WAS REVIEWED BY:

Therapist's Signature: _____ **Date:** _____

To Be Completed by Therapist:

Time of Day	Activity (Nap, Play time, Meal)	Duration of Activity	Quality of Activity	Behaviors Noted during Activity
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
10:00 AM				
11:00 AM				
12:30 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				