COMMUNICATION& FEEDING SPECIALISTS
• OF SOUTHEASTERN WISCONSIN •
CREATING PATHWAYS TO SUCCESS

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PEDIATRIC FEEDING HISTORY FORM

CHILD'S NAME: _____ DATE OF BIRTH: _____

1. Please explain, is your own words, what your child's current feeding problem is:

2. Was your child breast fed? From when to when: _____

Was your child bottle fed? From when to when: _____

Please describe your child's initial skill on the breast and/or bottle, including any necessary interventions.

3. During these early feedings, did your child frequently arch, cry, spit up, gag, cough, vomit or pull off the nipple?

Circle the behaviors shown and describe when they would happen, why, for how long:

4. Describe how the weaning process off the breast and/or bottle went and why the child was weaned:

5a. At what age did your child transition to: Baby cereal? _____ Baby food? _____
Finger foods? _____Transition fully to table food? _____

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5b. Please describe how these transitions were handled by your child, especially if any difficulties happened:

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

6a. List the foods that your child currently will eat and drink (put a star next to their favorites):

6b. List the foods your child refuses:

- Carbohydrates:
- Fruits:
- Vegetables:
- Proteins:

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6c. List the foods your child is allergic to:

6d. Describe your child's mealtime:

Who typically feeds your child? _____

Who typically eats with your child? _____

What type of chair is used? _____

How long are meals typically? _____

Does your child use utensils or any type of special cups/bowls (describe)? _____

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

6e. What times does your child typically eat and what type (bottle, breast, solids)?

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

7a. What type of formula is used and how do you mix it (if not skip to 8.)?

7b. Please detail your child's feeding schedule below.

Time of feeding (start time)	NG, G or Continuous	Amount	Gravity or Pump	Over what time period or what rate

7c. Describe where your child is tube fed and what activities are occurring at the same time:

7d. Describe your child's reactions to the tube feedings (connecting, during, disconnecting):

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*PLEASE ANSWER FOR ALL CHILDREN

8. Has your child ever been on any type of special diet other than what you just described?

If yes, please describe type of diet, at what ages, why and what was your child's response:

9. How do you know your child is hungry or full?

10. Has your child lost or gained any weight in the last 6 months, and how much?

11. Would you describe your child's weight as (circle one): Ideal Underweight Overweight

12. Does your child have/had any of the following problems? Please describe:
Dental, frequent constipation, frequent diarrhea, vomiting, choking, gagging, coughing

Check any that apply:

- ☐ Less than three bowel movements a week
- ☐ Bowel movements that are hard, dry and difficult to pass
- ☐ Large-diameter stools that may obstruct the toilet
- ☐ Pain/fear/avoidance while having a bowel movement
- ☐ Abdominal pain
- ☐ Traces of liquid or clay-like stool in your child's underwear — a sign that stool is backed up in the rectum
- ☐ Blood on the surface of hard stool
- ☐ Distended abdomen

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13. Does your child take a vitamin supplement? Which one?

14. Describe how you, and your child feel after a feeding:

You:

Your child:

15. What other evaluations have been completed regarding your child's feeding difficulties and what were the results/what were you told?

16. What treatments have been tried for this problem, and what were the results?

17. How can we be most helpful to you and your child?