Feeding Child History Form

Date:____
Child's Name:____
Child's Age: ________________________
Date of Birth:____
Parent's Name:____
Phone: (Home)______________________(Work)________________________________
Email:____
Emergency Contact:____
Child's Address:____
Child's Doctor:____
Sisters and Brothers in the household:
Name: Age:
____
____
____
____
Name of the person completing this form:_______________________________________
Relationship to child:____

Does your child have any food allergies or sensitivities that you are aware of? Yes No
If yes, which foods?____

Are there any additional diet restrictions due to personal, cultural, or religious reasons that we should be respectful of? (Ex. Vegetarian, Vegan, Gluten-free, No pork) Yes No
____

Does your child have a latex allergy? Yes No

Does your child have an allergy to food coloring? Yes No
If so, what color? _____________________________

STATEMENT OF THE PROBLEM:
Reason for referral: ____

Monkey Mouths
1809 Precinct Line Rd.
Hurst, TX 76054

Monkey Mouths Too
370 S State Hwy 121 Ste, 105
Coppell, TX 75019

Monkey Mouths FW
7217 Hawkins View Dr. Ste. 201
Fort Worth, TX 76132

Describe the problem:

____
____
____

Is this the first feeding evaluation for this child? Yes No

If not, who else has seen this child?

Who When Outcome

____
____
____

What skills do you hope your child will gain if therapy is warranted?

____
____
____

MEDICAL HISTORY:

Were there any problems during pregnancy, birth or delivery? Yes No

If so, please explain:

____
____
____

Was your child born prematurely? Yes No

If yes, at how many weeks? ____

Is there any history of medical concerns? Yes No

Please describe any medical concerns, injuries, illnesses, or surgeries:

____
____
____
____

Has your child been evaluated by other professionals (i.e. Occupational Therapy, Physical Therapy, Psychology, etc.)? Yes No
If so, please explain:

____
____
____

Has hearing been tested? Yes No

Where?____
When?____
Results____
____

Please list any medications this child is currently taking:

____
____
____
____

FEEDING HISTORY

Has your child had an NG-tube, G-tube, Fundoduplication, or been NPO? Yes No
If so, please describe in detail

____
____

Has your child had a Modified Barium Swallow study? Yes No

Where?____
When?____
Results/Recommendations:____

Do you have to make modifications to foods during meals/snacks? Yes No

If yes, please circle which ones:

Thickening Liquids   Cutting food into smaller bites
Alternating food/drink   Multiple swallows

Monkey Mouths
1809 Precinct Line Rd.
Hurst, TX 76054

Monkey Mouths Too
370 S State Hwy 121 Ste, 105
Coppell, TX 75019

Monkey Mouths FW
7217 Hawkins View Dr. Ste. 201
Fort Worth, TX 76132

What equipment is currently used to feed your child? (check all that apply)

Breast__________ If so, how frequent? ____

Bottle __________ If so, list type(s) ____

Open cup _____________ Spoon _________________ Sippy cup (hard)________________

Straw ________________ Fork ___________________ Sippy cup (straw)_______________

Squeeze packets _______________

Other ____

Do you use any special spoons, cups, nipples, etc. for feeding (i.e. latex covered spoon, preemie nipple, training cup, cut-out cup, etc.)? ____

Who usually feeds your child? ____

Where is your child fed (i.e. in a highchair, in your lap, in front of the TV, with reinforcers like the IPAD)?____

How does your child react to new tastes, smells, and textures? (circle all that apply)

Refuses to touch new foods crying/kicking

Sensitive to smells throws food

Vomiting Gagging

Choking Tries food when presented

Other:__________________________________

What does your child do if he/she doesn't like the food? Aversive response?

____

What do you currently do when a food is refused or your child gags or vomits?

____

Monkey Mouths
1809 Precinct Line Rd.
Hurst, TX 76054

Monkey Mouths Too
370 S State Hwy 121 Ste, 105
Coppell, TX 75019

Monkey Mouths FW
7217 Hawkins View Dr. Ste. 201
Fort Worth, TX 76132

FEEDING DEVELOPMENT

Foods	Check all the foods that your child currently eats
Breast milk/bottle/formula	
baby cereal (rice cereal)	
Stage 1 baby food/smooth puree (fruits, vegetables, meats)	
Stage 2 baby food	
Whole milk	
Crunchies (crackers, Cheerios, Cheetos, etc.)	
table foods/soft mashed foods (mashed cooked carrots, etc.)	
meltable foods (yogurt melts, etc.)	
soft cubed foods (cubed cheese, etc.)	
soft mechanical foods (banana, etc.)	
Stage 3 foods/mixed texture (pizza, soup)	
soft table foods (chicken, green beans, etc.)	
Chewy foods (steak, beef jerky, caramel)	
hard foods (carrots, celery, etc.)	

FEEDING SCHEDULE

How many meals/snacks does your child eat per day? 1 2 3 4 more

How long does it take to feed your child? 20 mins 30 mins 40 mins 60 mins or longer

What is the average amount of food and liquid your child eats/drinks during that time?

____

Food likes include:

____

____

Food dislikes include:

____

____

What does a typical feeding day look like for your child?

Time	Food Offered	Amount Taken

MISCELLANEOUS INFORMATION

Does your child dislike brushing hair or teeth? Yes No
Does your child use a pacifier? Yes No
Does your child suck his/her thumb, fingers, clothing? Yes No
Can your child suck his/her fingers or hands or use hands to wipe food/saliva from his/her mouth? Yes No
Does your child drool? Yes No
Is your child currently mouthing on objects (toys, food, etc.)? Yes No
Does your child mind having his/her face or hands dirty? Yes No

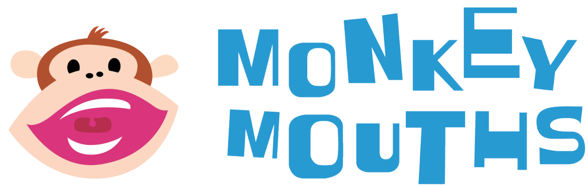
INTEREST INVENTORY:
What are your child's interests and favorite activities?

____
____
____

Does your child have any fears (i.e. stuffed animals, loud noises)?

____
____

Does your child receive special help in school? Yes No
If so, please explain: ______________________________
____
____



Is there anything else you wish to add that would help insure a positive testing experience for your child?

____

____

____

Thank you very much for your help and for the information you provided in this case history form. If you have questions before your intake or diagnostic appointments, please contact us at (817) 479-7019.