



The Children's Hospital of Philadelphia
PEDIATRIC FEEDING AND SWALLOWING CENTER

34th Street and Civic Center Boulevard, Philadelphia, PA 19104-4399
Phone (215) 590-7491 Fax (215) 590-9338

Feeding History Questionnaire

You must complete this form prior to your child's visit. Please mail or fax it back to us at (215) 590-9338 at least 10 days before your appointment which is scheduled for: _____

Today's date: _____

Child's name: _____ Date of birth: _____ Sex: M F

Person completing this form: _____ Relationship to child _____

1. What concerns do you have about your child's eating that you would like help with at this visit?

2. What do you hope to gain from this appointment?

3. The Social Worker is available at the Main Campus or by phone. Do you have any questions for the Social Worker? Yes No

I. GENERAL HISTORY

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

- | | |
|---|---|
| <input type="checkbox"/> gagging/coughing on textures | <input type="checkbox"/> choking |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> limited volume/not eating enough |
| <input type="checkbox"/> eats a limited variety of food/selective | <input type="checkbox"/> difficulty swallowing |
| <input type="checkbox"/> slow weight gain | <input type="checkbox"/> refuses to swallow/holds food in mouth |
| <input type="checkbox"/> refuses to eat | <input type="checkbox"/> difficulty progressing to table food |
| <input type="checkbox"/> other (specify) | |

Please describe: _____

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

3. What strategies have you tried to deal with your child's eating problems?

- distraction during meals (e.g. games, TV)
- skipping meals
- rewards
- feeding child when s/he requests food
- coaxing
- other (specify) _____
- forcing
- allowing child to drink more fluids
- giving preferred foods
- punishment
- high calorie supplements/formula

Please describe: _____

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 below:

None	Mild		Moderate				Severe			
0	1	2	3	4	5	6	7	8	9	10

II. 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) _____

Please describe: _____

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

- Gastroesophageal reflux (GER)
- apnea
- feeding and growth issues
- other (specify) _____
- mechanical ventilation
- CPAP therapy
- tube feedings
- bronchopulmonary dysplasia (BPD)
- necrotizing enterocolitis (NEC)
- intraventricular hemorrhage (bleeding in brain)

Please describe: _____

5. How long did your baby stay in the nursery? _____

III. MEDICAL HISTORY

1. Please note any of your child’s medical, developmental and/or mental health diagnoses.

- GE reflux
- failure to thrive/slow growth
- developmental delay
- esophagitis
- pulmonary (lung) issues (asthma)
- cardiac (heart)

issues

- neurologic (brain)issues
- slow stomach emptying
- constipation
- renal (kidney) issues
- eosinophilic esophagitis
- diarrhea
- autism/PDD
- mental health (specify) _____
- Genetic/chromosome abnormality (specify) _____
- other (specify) _____

2. How often does your child have a bowel movement? daily every other day
 other _____

Does s/he have issues with: Constipation (hard stools) Yes No Diarrhea (loose stools) Yes No

3. Does your child have any allergies? Yes No

If yes, please indicate:

- food _____
- medication _____
- contact _____ seasonal / environmental _____
- contrast dyes _____ adhesives/tape _____

IV. PEDIATRIC CARE

1. Does your child currently see any specialists? Yes No - If yes, please list below:

Name of Specialist	Specialty	Location	Date last seen

2. Does your child see a dietitian / nutritionist? Yes No – name: _____

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

- upper GI series
- milk scan
- modified barium swallow study
- endoscopy
- pH probe
- genetic (chromosome) testing
- head CT scan
- head MRI scan
- bone age film/x-ray
- allergy testing
- other (specify) _____

Were these tests done at CHOP? Yes No If no, please bring the results of these tests with you.

4. Please list your child's current medications. (Include vitamins and other 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 visit with the primary doctor? _____

(Please bring record of weight/growth history if available)

V. FAMILY HISTORY:

Are there medical problems that run in the family? (Parents, siblings, grandparents?) Please indicate:

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

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

VII. EATING ENVIRONMENT

1. Where does your child usually sit during mealtimes?
 - infant seat highchair booster seat chair at table
 - child stands child wanders around in front of TV held in caretaker's arms
 - on caretaker's lap other _____
2. Where in the house is your child fed?
 - kitchen dining room living room walking around
 - other (please 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 a mealtime?
 - Refuse to eat Tries to get out of seat
 - Spits out food Falls asleep
 - Cries/screams Gags/coughs
 - Vomits Throws food/utensils
 - Holds food in mouth

VIII. CURRENT FEEDING/DRINKING SKILLS

1. Who feeds your child?
 - Mother Father Sibling Grandparent Nurse
 - Teacher Daycare provider other (please 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 (please specify) _____
 - How is your child positioned during feeding?
 - seated held other (please specify) _____
 - e. When is bottle/breast offered? _____
 - f. Drinking from a cup? Yes No If yes, type of cup _____
 - g. 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 w/ 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. apple, crackers)					
Difficult to chew table food (e.g. meat)					

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

<u>Food Group</u>	<u>Examples</u>
Fruit	_____
Grains (bread/cereal/ pasta/rice)	_____
Vegetables	_____
Meats/egg/peanut butter	_____
Dairy (milk/cheese/yogurt)	_____

IX. TUBE FEEDING ASSESSMENT

- Does your child receive tube feeds: Yes No (If not, please skip this section)?
- What is the name and specialty of the Provider who tells you what to give through the tube?

- Type of tube used: NG G G-J
- Formula used: _____
- Schedule: (Include times and amount given) _____

X. 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

<u>Breakfast:</u>	Amounts of food and drink child actually eats/drinks

<u>Snack:</u>	Amounts of food and drink child actually eats/drinks

<u>Lunch:</u>	Amounts of food and drink child actually eats/drinks

<u>Snack:</u>	Amounts of food and drink child actually eats/drinks

<u>Dinner:</u>	Amounts of food and drink child actually eats/drinks

<u>Bed Time Snack:</u>	Amounts of food and drink child actually eats/drinks

XI. DEVELOPMENTAL/ SCHOOL

1. How old was your child when s/he achieved the following milestones:

Milestone	Age
Rollover	
Sit-up	
Walk	
First Words	
Toilet Training	

2. How many words does your child currently say? _____

3. Does your child receive any of the following services:

Service	Yes/No (please circle)	Duration and Frequency (i.e., 1 hour 3 times per week)	Who provides these services?
Occupational therapy	Yes No		
Physical therapy	Yes No		
Speech therapy	Yes No		
Feeding therapy	Yes No		
Behavioral therapy	Yes No		
Special Instruction/Education	Yes No		
Other therapy (Please specify):	Yes No		

4. Is your child in school? Yes No If yes, what year? preschool kindergarten grade level: _____

5. What is your child’s overall performance at school? below grade level at grade level above grade level

6. 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
- Has a high activity level
- Is easily upset
- Has difficulty calming down when upset
- Is easily distracted
- Is irritable or cranky

Please describe: _____

Please tell us anything else you think may be important for us to know about your child’s feeding history.
