ACHIEVE
SPEECH AND LANGUAGE

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PEDIATRIC FEEDING HISTORY FORM

CHILD'S NAME: _____ DATE OF BIRTH: _____

1. Please explain your child's current feeding problem/concern:

2. Was your child breast/bottle fed? Age? _____ Age? _____

If currently bottle feeding which type of bottle is used?_____

Please describe your child's initial skill on the breast/bottle and list any difficulties: (Circle any that apply and explain- include when, why, and how long) **Arch, Cry, Gag, Spit up, Reflux, Cough, Vomit, Pull-off nipple**

3. At what age was your child introduced to Baby cereal? _____ Baby food? _____

Finger foods? _____ Table food? _____

When did they Transition fully to table food? _____

Please describe how weaning and these transitions were handled by your child, especially if any difficulties:

4. List the foods that your child currently will eat and drink:

5. Circle the food types your child refuses (crunchy, soft, puree, sweet, salty, spicy, saucy, mixed textures, etc.) and list how they react when these foods are presented:

6. Who typically feeds your child or do they self feed_____

Who is present during meal times with your child? _____

Where does your child eat and in what type of chair?_____

How long do meals typically last?_____

Are any special utensils/dishes used? _____

What type of cup does your child drink from (bottle, sippy, straw, open cup)?_____

Are other activities happening at meal times (T.V., toys, I-pad, etc.)? _____

7. Has your child ever been on any special diet other than what you described previously (circle 1)? **YES NO**
   If yes, please describe type of diet, at what ages, why and what was your child's response:

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

   Full?

9. Has your child lost/gained any weight in the last 6 months, and how much?
(Circle one) **Ideal Underweight Overweight**

10. Does your child have/had any of the following problems (circle which ones)? Please describe:
    Dental, frequent constipation, frequent diarrhea, vomiting, choking, gagging, coughing, reflux

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

12. Describe how you and your child feel after a feeding:
    You:

    Your child:

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

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

Instructions:

Please record **ALL foods/drinks** consumed by your child for 3 consecuative days. The following directions will guide you in filling out the form. Please have this form ready to give to therapist upon arrival of appointment.

1. Please record the date and time any food/drinks were consumed. It is best to carry the history form with you and to record items immediately so that nothing is missed.

2. Include an EXACT description of the item and your best guess of the portion size of the amount eaten. Write the brand name of foods/drinks (i.e. Gerber,Kraft etc.), any special recipes (i.e. 24 calorie Isomil + 1 tsp Polycose), and any additions to foods (i.e. ¼ cup mashed potatoes + 1 Tbsp margarine).

Example:

Date	Time	Food/ Drink Item	Amount	Bottle	Cup	Mouth	G-tube
1/1/02	4 pm	Gerber applesauce #2	1 ounce			✔	
		White Bread (Wonder)	¼ slice			✔	
		Ham lunch meat (Hormel)	½ ounce			✔	
		Mayonnaise	1 tsp			✔	
		White grape juice	1 ounce		✔	✔	
	6:30pm	Veggie Straws (Whole Foods 365)	5			✔	
		Diced pears (Del Monte)	1 plastic container			✔	
	7 pm	Similac Advance Formula	4 ounces	✔		✔	
	9 pm	Pediasure with fiber	8 ounces				✔

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