6520 3rd Street Rockledge, FL 32955 P (321) 622-8792 F (321) 622-8793

CASE HISTORY FOR INFANTS/CHILDREN WITH FEEDING PROBLEMS

Child's Name:_____ Date of Birth_____

Primary caregiver(s)_____

Home Address:_____

City_____ State_____ Zip_____

Phone (home)_____ Cell_____

Primary care physician_____

Other physicians who see the child_____

Why is your child being seen for a feeding evaluation?_____

_____

When did these problems begin?_____

Please list anyone else who has evaluated your child for this feeding problem_____

_____

Father's email address:_____

Mother's email address:_____

I consent to receiving email communication Yes ◯ No ◯

Child's School_____ Grade_____ Teacher_____

Insurance Information

Insured's Name (if different from patient)_____

Relationship to patient:_____ Date of birth_____

Insurance:_____

Group#_____ ID or SS#_____

Insurance Phone_____

Referred by_____

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Prenatal and Perinatal Medical History

Weight of your child at birth_____Was your child full term?_____

If premature, how many weeks gestation?_____ How long was your child hospitalized after birth?_____

Describe any problems during pregnancy._____

_____

Describe any problems during or immediately after birth. _____

_____

Apgar scores _____(1 minute) _____ (5 minutes)

Postnatal Medical History

Does your child have any medical diagnoses? If yes, please list._____

_____

Describe any family history of similar problems. _____

_____

If your child has ever been hospitalized, list dates and reasons. _____

_____

Describe any special medical tests. _____

_____

If your child has had any surgeries, list dates and reasons. _____

_____

Describe any dental problems. _____

_____

Describe any respiratory problems (e.g. pneumonia, bronchitis, asthma, noisy breathing). _____

_____

Describe any gastrointestinal problems (e.g. vomiting, diarrhea, constipation, gas). _____

_____

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List any medications your child takes and the reason for the medicine. _____

_____

Describe any allergies. _____

_____

Does your child chew and bite on toys? _____ Does your child let you brush his/her teeth? _____

Sleep Patterns

When does your child go to bed at night? _____ How many hours does he/she sleep? _____

Does your child nap during the day? _____ If yes, when and how long does your child sleep? _____

_____

Does your child sleep through the night? _____ Does your child snore? _____

Is your child a mouth breather when asleep? _____

Developmental History

Please tell the approximate age your child reached the following milestones:

_____Sat Unsupported _____ Walked _____Crawled

_____Dressed self _____ Stood alone _____was potty trained

Food and Nutrition

Feeding Milestones

Was your child breast-fed? _____ If yes, for how long? _____ Does your child still breast-feed? _____

Did your child have any trouble with breast-feeding (e.g. poor suck, slow to feed, poor latch)? _____

If yes, please describe. _____

_____

When was your child's first bottle? _____ Did your child have any trouble with the bottle? _____

If yes, please describe. _____

At what age did your child try cereal? _____

Describe any problems encountered with spoon feeding cereal and other solids. _____

_____

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When was your child weaned from the breast or bottle to cup drinking? _____

Describe any problems with moving to cup drinking. _____

At what age did your child begin to eat foods that require biting and chewing? _____

Describe any problems with biting or chewing. _____

_____

Current Information

What is your child's current weight? _____ height? _____

Where does your child fall on the growth charts? _____ percentile weight _____ percentile height _____

How would you describe your child's appetite? ☐ good ☐ fair ☐ poor ☐ varies

Please explain. _____

_____

Describe a typical meal (include what your child eats and drinks and how much of each).

Breakfast _____

Lunch _____

Dinner _____

Snack _____

What consistency of food does your child eat?

☐ smooth baby food ☐ semi-chunky baby food ☐ chunky baby food

☐ mashed table food ☐ regular table food

What kind of liquid does your child drink?

☐ regular (thin) liquids ☐ thickened liquids (What is used to thicken the liquid)? _____

Which of the following does your child drink?

☐ cow's milk ☐ soy milk ☐ breast milk ☐ formula

If your child is nursing, does mother have adequate production of milk? _____

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How much of the following does your child eat and drink in a typical 24-hour period?

food_____ liquid _____ supplements_____

Does your child drink juice? _____ If yes, how much in a day? _____

When? ☐ before meals ☐ during meals ☐ after meals

What are your child's favorite foods/liquids? _____

_____

What temperature foods and liquids does your child prefer? ☐ room temperature ☐ warm ☐ cold

What are some foods/liquids your child does not like/refuses? _____

_____

What foods are easy for your child to eat? _____

_____

What foods are difficult for your child to eat? _____

_____

How many times a day does your child eat? _____ How long is it between meals? _____

How long does each meal take? _____

Does your child use any special equipment to eat? ☐ bottle ☐ nipple ☐ cup ☐ spoon

If yes, please describe. _____

Does your child self-feed? _____ If yes, how? ☐ with fingers ☐ with spoon ☐ with fork

Does your child hold any of these items independently? ☐ bottle ☐ cup with spout ☐ regular cup

What is your child's position when eating/being fed?

☐ held by caregiver (describe position) _____

☐ in high chair ☐ in seating device

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Does your child eat more/less/same amount in the following situations?

with other relatives _____ with other adults (e.g.) babysitter _____

At school/daycare _____ with others _____

Does your child receive any supplemental feeding? _____

If yes, please select: ☐ NG ☐ PEG ☐ PEJ ☐ oral supplements

Response to Feeding/Mealtime Interaction

Where does your child typically eat at home? _____

Who usually feeds your child? _____

Which, if any, of these behaviors does your child exhibit during a meal?

☐ crying ☐ spitting out food ☐ holding food in mouth ☐ gagging ☐ vomiting

☐ getting down from table ☐ throwing food ☐ refusing to eat

☐ turning head away clamping mouth shut

When this happens, what do you do? _____

_____

_____

_____ _____

Person completing form Date

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PLEASE READ AND SIGN THE FOLLOWING

I give permission for Taylor Made Therapies LLC and contracted therapists to evaluate and treat my child.

Signature_____ Date_____

I have reviewed and received Taylor Made Therapies LLC's HIPAA Policy Statement.

Signature_____ Date_____

I authorize release of any medical or other information necessary to process this claim, including release of information to my Primary Care Physician as designated above and directly to the insurance company. I authorize payment of medical benefits to Taylor Made Therapies, LLC for services provided. I request and assign benefits to Taylor Made Therapies, LLC for all insurance benefits otherwise payable to me for services rendered.

Signature_____ Date_____

I authorize discussion of my case with the following specific individuals:

_____

_____

_____

_____

_____

Signature_____ Date_____