CASE HISTORY FORM – CHILD FEEDING (6 MONTHS-10 YEARS)

Please complete this information and email it to Beth Cortes at bcortes@paspeech.com or mail it to the address below, if necessary. If you have any previous evaluations or reports that you feel would be helpful, please send them along with this form.

IDENTIFYING INFORMATION

Child's Name _____ Birthdate _____ Sex _____

Parents _____ Caregiver _____

Address_____

Street City State Zip

Phone: Home _____ Work _____ Cell _____ Other _____

Email _____

Preferred mode of communication (rank in order): Home ____ Cell ____ Email _____ Text ____ Other _____

Preferred Language(s) spoken in the home: _____ Other Language(s): _____

Pediatrician _____ Referral source _____

Other Physicians _____

Other Physicians _____

Other Physicians _____

Appointment Availability (please circle): Morning Afternoon M T W Th F

Are you interested in Home-based or Clinic-based treatment? (circle one) Home Clinic

GENERAL QUESTIONS

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

When did these problems begin? _____

Has your child received a feeding evaluation in the past? If so, when and by whom? Please include all previous reports.

760 Polhemus Road
San Mateo, CA 94402
T (650) 349-8717 | F (650) 349-0350

120A Santa Margarita Avenue
Menlo Park, CA 94025
T (650) 324-0648 | F (650) 324-9880

550 Water Street. Suite F-1
Santa Cruz, CA 95060
T (831) 247-8126 | F (831) 426-0145

_____

_____

_____

_____

FAMILY INFORMATION

Parent's Name:_____

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

Parent's Name:_____

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

If both primary caregivers work, who cares for the child? _____

Phone #:_____When is the client in this childcare facility?_____

Client lives with: (1) Both Parents (2) Mother (3) Father (4) Other:_____

Children in the family

Name	Age	School Status	Relationship to Client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others living in the home

Name	Age	Relationship to Client
_____	_____	_____
_____	_____	_____

Is there any history of speech, language, and/or hearing problems in other family members? If so, please describe._____

_____

_____

Are there any family stressors that may impact the client's behavior?

Item	No	Yes	Event	Explanation
1			Marital separations/divorce	
2			Death in the family	
3			Financial crisis	
4			Job change/difficulties	
5			School problems	
6			Legal problems	

7			Medical problems	
8			Household move	
9			Extended separation from parents	
10			Other stressful event(s)	

BIRTH HISTORY (for the child being evaluated):

1. Hospital where born + city + state:_____

2. Pediatrician's Name:_____

3. Gestational Age at time of delivery (or # weeks early or late): _____

4. What were the baby's APGAR scores? 1 minute _____ 5 minutes_____

5. What was the baby's Birth Weight? _____ Birth Length _____

6. What was the condition of the infant while in the nursery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc):

Item	No	Yes	Description	Explanation
1			Was blue/cyanotic at birth	
2			Required stimulation to breathe	
3			Required oxygen at birth	How much/what type?
4			Required resuscitation	
5			Was considered small for gestational age	
6			Had tremoring or seizures	Which/for how long?
7			Very low tone	
8			Brain hemorrhage	
9			Anemia and/or transfusions	Which/how many times?
10			Jaundice (yellow)	How much/how treated?
11			Had bruising	
12			Rh incompatibility problems	
13			Infections	
14			Congenital birth defects	
15			Aspiration (meconium or fluid)	Which/how treated?
16			Respiratory distress signs or syndrome	
17			Needed ventilation	What type/how long?
18			Choking or vomiting episodes	
19			Tube feedings	
20			Needed medications	

MEDICAL HISTORY

It is very important to have as complete a medical history for the client as possible. Please fill out the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include the client's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

Item	No	Yes	Description	Explanation
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	
3			Frequent Ear Infections (?tubes)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Kidney/Renal disorder	
9			Urinary problems/infections	
10			Hormonal problem	
11			Muscle disorder/muscle problem	
12			Joint or bone problems	
13			Skin disorder/skin problems (eczema)	
14			Visual disorder/vision problems	
15			Eye infections	
16			Neurological disorder	
17			Seizures or convulsions	
18			Stomach disorder/stomach pain	
19			Vomiting/digestion problems	
20			Failure to gain weight/feeding problems	
21			Constipation/diarrhea problems	
22			Dehydration episodes	
23			Hearing Loss	
24			Head injuries or concussions	
25			Ingestion of toxins, poisons, foreign objects	
26			Major medical procedures (detail below)	
27			Chronic medications (for what? when?)	
28			Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	
29			Dental problems	

HOSPITALIZATIONS AND/OR SURGERIES: Date(s) and Reason(s)

1. _____ _____

2. _____ _____

3. _____

4. _____

PRESENT HEALTH STATUS: Most recent Height = _____ Weight = _____Date: _____

Please note any illnesses for which the client is currently being treated, including their Current

Medications:_____

_____

_____

FEEDING HISTORY:

1. Please explain, in your own words, what the client's current feeding problem is (if any)

_____

_____

_____

_____

2. Was the client breast fed? _____ From when to when? _____

   Was the client bottle fed? _____ From when to when? _____

Please describe the client's initial skill on the breast and/or bottle:

_____

_____

_____

_____

3. During these early feedings did the client frequently arch, cry, spit up, gag, cough, vomit or pull of the nipple? Circle any behaviors you saw and describe when they would happen, why and for how long.

_____

_____

_____

_____

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

_____

_____

_____

5. At what age did the client transition from Baby cereal? _____ Baby food? _____

Finger Food? _____ Transition fully to table food _____

Please describe how these transitions were handled by the client, especially if any difficulties happened.

_____

_____

_____

_____

6. Has the client ever been on any type of special diet other than what you just described? _____
If yes, please describe the type of diet, at what ages, why and what was the client's response.

_____

_____

_____

_____

7. Describe a typical meal. Include what your child eats and drinks and how much of each.

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Other: _____

8. Which of the following does your child drink? ☐ cow's milk ☐ soy milk ☐ breast milk ☐ formula

9. Indicate with a check mark any aversions/problems or preferences your child may have. Included are examples of each food group.

	Likes	Dislikes	Refuses	Difficulty Managing
Thin Liquids (i.e. water)				
Thick Liquids (i.e. milkshakes)				
Purees (i.e. pudding)				
Textured puree (i.e. applesauce)				
Mixed Texture (i.e. cereal with milk)				
Soft Solids (i.e. banana, cheese)				
Crunchy Solid (i.e. Cheeto, Cracker)				
Chewy Solid (i.e. meat)				
Cold foods				
Room temperature foods				
Warm foods				

10. What are your child's favorite foods and liquids? _____

11. Does your child have food preferences based on color, shape, flavor (sweet, salty, sour)? If yes, please explain.

_____

_____

_____

_____

12. Does your child have any food allergies or intolerances that you are aware of? Please list these. If your child has food allergies that require an Epi pen, please be sure this is present for every session [PLEASE NOTE: FOR SAFETY PURPOSES, A FEEDING SESSION WILL NOT TAKE PLACE IF YOUR CHILD HAS ALLERGIES AND AN EPI PEN IS NOT PRESENT]

_____

_____

_____

_____

13. How many times per day does your child eat? _____ How long is it between meals? _____

14. How long does each meal take? _____

15. Does your child use any special equipment to eat? ? ☐ bottle ☐ nipple ☐ cup ☐ spoon ☐ plate
If yes, please describe: _____

16. Does your child self-feed? _____ If yes, how? ☐ fingers ☐ spoon ☐ fork ☐ straw ☐ open cup

IF THE CLIENT IS TUBE FED, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. What type of formula is used and how do you mix (i.e. pre-blended, blender)?

_____

_____

2. Please detail the client's feeding schedule below.

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

3. Describe where the client is tube fed and what activities are occurring at the same time.

_____

_____

4. Describe the client's reactions to the tube feedings (connecting, during, disconnecting)

_____

_____

DEVELOPMENTAL/SOCIAL HISTORY

We would like to have information about the client's developmental milestones. Indicate the age when the client first performed each of the following INDEPENDENTLY. If you can not recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If the client has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

MILESTONE	AGE	EARLY	ON TIME	LATE	GOOD/ FAIR	POOR
Smiled						
Held head up						
Rolled over						
Reached for an object actively						
Transferred object between hands						
Sat unsupported						

Crawled						
Stood alone						
Walked by himself/herself						
Said first words						
Threw objects actively						
Ran by himself/herself						
Followed simple 1 step directions						
Said 2-3 phrases						
Ate unaided with a spoon/fork						
Dresses by himself/herself						
Rode bicycle without training wheels						
Caught a thrown object						
Demonstrated handedness (which?)						
Knew colors						
Counted to 5						
Knew alphabet						
Potty Trained						

1. Do you feel the client was "faster" or "slower" than his/her peers in any other way? Please explain .

_____

_____

2. If the client is in school, please describe any difficulties or strengths in reading, writing or spelling:

_____

_____

3. Name of current school: _____ Grade: _____

Any special educations services (which, when)?_____

Teacher:_____

What comments have other adults, e.g., teachers, made about the client's speech and language?

_____

_____

5. How does the client relate to peers?

_____

_____

6. Compared to other children of similar age, how would you describe the client's overall behavior and ability to listen to and follow directions?

_____

_____

7. Has the client had problems with any of the following (beyond expected for child's age):

Item	No	Yes	Description	Explanation
1			Sleeping problems	
2			Bed wetting	
3			Drooling	
4			Thumb sucking	
5			Temper tantrums	
6			Head banging	
7			Breath holding	
8			Aggression/destructiveness	
9			Nervous habits (nail biting etc)	
10			Masturbation	
11			Major mood swings	
12			Under or over reactive to sounds	
13			Under or over reactive to clothing	
14			Under or over reactive to taste	
15			Under or over reactive to smell	
16			Any unusual fears?	

If there is anything else you feel would help us better prepare for this client's evaluation, please let us know.

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Client/Parent Signature Date