7209 Creedmoor Rd. Suite 101
Raleigh, NC 27613
Office 919.844.1100 • Fax 919.844.1102
Office@PediatricPossibilites.com
www.PediatricPossibilities.com

Pediatric POSSIBILITIES, P.A.
"Making it Possible"

211 West Matthews St. Suite 101
Matthews, NC 28105
Office 980.245.2340 • Fax 980.245.2333
Office@PediatricPossibilities.com
www.PediatricPossibilities.com

PEDIATRIC FEEDING HISTORY FORM

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

1. Please explain, in your own words, what your child's current feeding problems are:

_____

_____

_____

_____

_____

2. Was your child breast fed? _____ From when to when _____

   Was your child bottle fed? _____ From when to when _____

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

_____

_____

_____

3. During these early feedings, did your child frequently arch, cry, spit up, gag, cough, vomit or pull off the nipple? Circle which of the above occurred and describe when they would happen, and why, and for how long:

_____

_____

_____

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

_____

_____

_____

5. 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 these food transitions were handled by your child, especially if any difficulties happened:

_____

_____

IF YOUR CHILD EATS BY MOUTH, PLEASE ANSWER THE FOLLOWING QUESTIONS:

6a. Please list all of the foods your child will eat. Be as *specific* as necessary; for example if your child will only eat a certain brand of food (such as "Wendy's" chicken nuggets) or only a certain flavor (such as if your child eats only strawberry yogurt). Please put a star next to favorites! It is also helpful for us to know if there are certain foods your child only eats sometimes; or that s/he used to eat but currently refuses.

Proteins Includes dairy, nuts, meats	**Starch / Carbohydrates**	**Fruits / Vegetables**	**Beverages**

6b. List the foods your child refuses to eat:

_____

_____

_____

6c. List the foods your child is allergic to:

6d. Describe your child's mealtime:

Who typically feeds your child? _____

Who typically eats with your child? _____

What type of chair is used? _____

How long do meals typically last? _____

Does your child use utensils or any type of special cups/bowls (describe)? _____

Are there any other activities going on at meals (i.e. TV etc)? What activities (describe)? _____

7. Has your child ever been on any type of special diet? **YES NO**
If yes, please describe type of diet, at what ages, why, and what was your child's response:

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

Hungry?

Full?

10. Has your child lost or gained any weight in the last 6 months, and how much?

11. Would you describe your child's weight as (circle one): Ideal Underweight Overweight

12. Does your child have/had any of the following problems (circle which ones)? Please describe:

Dental:

Frequent constipation:

Frequent diarrhea:

Vomiting:

Choking:

Gagging:

Coughing:

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

14. Describe how you, and your child feel after a feeding:

You? _____

_____

Your child? _____

_____

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

_____

_____

_____

16. What treatments have been tried for this problem, and what were the results?

_____

_____

_____

17. Has your child received any other therapy services? If so, describe below:

Dates (duration) Type of therapy Comments

_____

_____

_____

_____

_____

_____

18. Birth history:

Age of mother at pregnancy: ____ General health of mother:_____

Prenatal complications: _____

☐ Full term ☐ Premature: ___ weeks ☐ Vaginal ☐ Caesarean: _____

Birth weight ___lb ___oz Apgar score: ___

Labor/Delivery difficulties: ☐ Y ☐ N _____

Post-natal complications: ☐ Y ☐ N _____

Intensive Care: ☐ Y ☐ N Length: _____

19. Medical History:

Illnesses: _____

History of Ear Infections: _

History of reflux:_____

Seizures: _____

Surgeries: _____

Current Medications: _____

Previous Medications: _____

Allergies: _____

Other diagnoses: _____

20. Developmental Information: *list the age your child reached each of the following milestones*

Rolled _____ Sat alone _____

Crawled _____ Belly/commando crawl_____ Hands and knees crawl_____

Cruised _____ Walked _____

How did your child tolerate tummy time as an infant?_____

Describe how your child crawled (on tummy, on hands and knees) and for how long

_____

Describe if your child had any difficulty achieving motor milestones. _____

_____

School/Work/Productive Activities:

21a. Explain how your child participates in family routines and chores. Include your child's willingness and independence. Include how your child assists with picking up their toys, clothing, making their bed, puts their dishes away, etc.

_____

_____

21b. If applicable, please describe how your child completes homework. Include level of independence, need for breaks, need for external supports (food, music) the amount of time typically needed.

_____

_____

21c. Is your child able to follow classroom rules, (i.e. no talking out of turn, hands to self, follow directions, completes work on time, work independently, etc.)

_____

_____

Hygeine/Self Care

22a. Describe a typical bath time for your child. Include the level or independence in bathing and what your child likes and dislikes about bath time.

_____

_____

22b. Hygiene skills: (please describe the level of independence and behavior for each of the following:

Teeth brushing _____

Hair brushing _____

Washing hands and face _____

Wash body and wash hair_____

22c. Sleep: Please describe how your child sleeps: easy to go to bed, hard to go bed, wakes during the night, hard to wake in the morning, wake up time)

_____

_____

22d. Please describe how your child makes transitions between people or environments. Include level of independence during transitions, need for transitional objects, need for advanced preparations, etc.

_____

_____

Play/Social Skills

23a. Please describe your child's typical play skills. Include information about the ages of the people your child chooses to play with, if your child chooses to be a leader, a follower, or prefers to play alone.

_____

_____

Does your child play *next to* other kids (parallel play) or *with* other kids?_____

23b. Describe what your child's favorite play activities and the variety of toys your child plays with. _____

_____

23c. Circle the following that your child does easily: slide, swings (pumping), monkey bars, catch and kick a ball, run, skip, ride a bike (2 wheels, 3 wheels). Describe your child's response to playground activities:

_____

23d. Does your child participate in group/community activities such as scouts or sports? Please describe your child's ability and behavior while participating in these activities.

_____

_____

23e. Describe your child's behavior on outings such as shopping, birthday parties, restaurants, family vacations. Indicate if any of these activities are difficult for your child and explain why you think they are.

_____

_____

24. What do you see as your child's strengths?

_____

_____

25. What are your concerns about your child?

_____

_____

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

_____

_____

_____

_____