

Pullman Feeding Team for Children Case History Form

DATE OF APPOINTMENT: _____ **TIME:** _____

LOCATION: 1620 SE Summit Ct., Pullman, WA 99163

Child's Name: _____ **Age:** _____ **Birthdate:** _____

Parent/Guardian Name(s): _____

Home Phone: _____ Work Phone: _____ Email: _____

Address: _____

Child's Pediatrician: _____

Birth History:

1. Did the mother have a complicated pregnancy? *If, yes, specify* _____ Yes No
2. Was the mother taking any drugs or medications during pregnancy? Yes No
3. Was the pregnancy full term? *If no, baby born at _____ weeks.* Yes No
4. Was the delivery complicated? *Breech or Caesarean* Yes No
5. Was the child considered low birth weight? Yes No
6. Were there any complications such as:
 - a. Cyanosis Yes No
 - b. Jaundice Yes No
 - c. Congenital Defect Yes No
 - d. Other: _____ Yes No
7. Was there a need for:
 - a. Oxygen Yes No
 - b. Transfusion Yes No
 - c. Tube Feeding Yes No

Medical History of Child:

Has your child had any of the following: Check all that apply

(Note if Child has had immunization in space provided)

- | | | | |
|--|--|--|---------------------------------|
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Fevers | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Infantile Colic | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Lung/Bronchial Difficulties | |
| <input type="checkbox"/> Otitis Media (ear infection) How many _____ Treated with Antibiotics or Tubes _____ | | | |
| <input type="checkbox"/> Physical Injury/Illness requiring Hospitalization: Specify: _____ | | | |
| <input type="checkbox"/> Other Chronic Illness: Specify: _____ | | | |

Does your child have a visual impairment? Yes No

Does your child have a hearing impairment? Yes No

Is your child on any Medications? *Please list medication, reason for taking, and dosage.*

How is your Child Eating and Growing? (Please circle yes or no in response to the following questions)

- | | | | |
|--|-----|----|----------------------|
| 1. Is it easy to tell when your child is hungry or thirsty? | Yes | No | |
| 2. Do you worry about his/her eating or growing? | Yes | No | |
| 3. Have you received any special directions for feeding your child? | Yes | No | |
| 4. Does he/she take vitamins or minerals? | Yes | No | If Yes, what? _____ |
| 5. Does he/she take herbal or other supplements? | Yes | No | If Yes, what? _____ |
| 6. Does he/she take medications? | Yes | No | If Yes, what? _____ |
| 7. Does your child eat anything that is not food, such as paint or dirt? | Yes | No | |
| 8. Do you have trouble buying or making your child's food? | Yes | No | |
| 9. Is your child on the WIC Program? | Yes | No | If Yes, where? _____ |
| 10. Does your child go to daycare or school? | Yes | No | If Yes, where? _____ |
| 11. Is your child fed by any other people? | Yes | No | If Yes, where? _____ |

What Does Your Child Eat and Drink?

- At what age did you begin to introduce solids? _____
- Where do you usually feed your child? _____
- How many meals and snacks does he/she eat most days? _____ Meals _____ Snacks
- How long does it take your child to eat? _____ Minutes
- Please check what your child eats:

<input type="checkbox"/> Breastmilk	<input type="checkbox"/> Baby Cereal	<input type="checkbox"/> Ground Meats/Finely Ground Table Foods
<input type="checkbox"/> Formula	<input type="checkbox"/> Strained Baby Foods	<input type="checkbox"/> Cut Up Meats/Soft Table Foods
<input type="checkbox"/> Cows Milk	<input type="checkbox"/> Junior Foods	<input type="checkbox"/> Finger Foods
<input type="checkbox"/> Whole <input type="checkbox"/> 2%	<input type="checkbox"/> Skim	<input type="checkbox"/> Juice
- Circle the foods that you feel your child does not eat enough of:

Milk and milk products	meat, beans, eggs	fruit and vegetables	bread and cereals
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- How much does your child usually drink in one day (24 hours):

Breast Milk: feedings per day _____	
Baby formula _____ ounces per day.	What kind of formula? (with/without iron?) _____
How do you mix the formula? _____	
Water _____	Sweet drinks _____ Juice _____ Cow's milk _____
Sports drinks _____	Other _____

Are any of these a problem for your child? (if yes, please check)

- | | | |
|--|---|---|
| <input type="checkbox"/> vomiting | <input type="checkbox"/> easily distracted when eating | <input type="checkbox"/> gagging or choking |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> overstuffs mouth | <input type="checkbox"/> throws food |
| <input type="checkbox"/> excessive gas | <input type="checkbox"/> sensitive around the mouth | <input type="checkbox"/> eating too slowly |
| <input type="checkbox"/> sucking on nipple | <input type="checkbox"/> chewing | <input type="checkbox"/> refusing foods offered |
| <input type="checkbox"/> holding up head | <input type="checkbox"/> cup drinking | <input type="checkbox"/> refusing to eat any food |
| <input type="checkbox"/> sitting up alone | <input type="checkbox"/> finger feeding | <input type="checkbox"/> spitting out food |
| <input type="checkbox"/> swallowing | <input type="checkbox"/> not eating solids after age one | <input type="checkbox"/> getting upset at meals |
| <input type="checkbox"/> diagnosis of reflux | <input type="checkbox"/> bad teeth or sore mouth | <input type="checkbox"/> picky eater |
| <input type="checkbox"/> using a spoon | <input type="checkbox"/> holding food in mouth (spillage) | <input type="checkbox"/> eating has become a "battle" |

Do you have any concerns about what your child eats and/or his/her eating skills?

Has your child ever had a swallow study? Yes ___ No ___ If yes, result?

Has your child ever been fed other than orally (tube feeding)? Yes ___ No ___ Please describe:

Does your child have any food restrictions/allergies (cultural/religious or other)? Yes ___ No ___

Does your child breast feed? Yes ___ No ___

Does your child self-feed? Yes ___ No ___

If yes, circle manner of feeding: holds own bottle uses spoon uses fork
finger feeds sippy cup regular cup

What have you tried in the past to improve feeding concerns?

Please list any questions you would like addressed or information you would like to receive from this evaluation:

Thank you for taking the time to complete this form. It is very helpful in the care of your child.

Sincerely,

The Pullman Feeding Team for Children