MedStar Georgetown University Hospital

Georgetown University Hospital
Pediatric Feeding and Swallowing Evaluation

Pediatric Feeding History Questionnaire

This form has important questions that help the therapists understand your child. Please fill in all areas that you can. ***Please bring any medical reports you have for our records.***

Completed by (Name/relationship to patient): _____Date:_____
Child's Name: _____ Date of Birth: _____ Age:_____
Address: _____
Main language used at home: _____ Other languages used:_____
Email: _____ Secondary Email: _____
Preferred Daytime Phone Number: (___)_____❒ Additional Phone Number:_____

Why are you coming for an evaluation? What are your main concerns?

_____
_____
_____

Has your child been previously evaluated or treated by an occupational therapist, physical therapist, or speech language pathologist? **Date(s) of Evaluation(s)?**

_____
_____
_____
_____

Please indicate any known adverse/allergic drug and/or food allergies (e.g., penicillin, latex, gluten):

_____
_____

Family History

Please indicate who lives at home and/or cares for your child:

Name	Relationship to Child (parent, sibling, nanny)	Contact Numbers	Medical Diagnoses	Occupation
		Home:_____ Cell:_____		
		Home:_____ Cell:_____		
		Home:_____ Cell:_____		
		Home:_____ Cell:_____		
		Home:_____ Cell:_____		

MedStar Georgetown University Hospital

Family Medical History

❒ Biological Child ❒ Adoption ❒ Foster care ❒ Surrogacy

Age at adoption/foster care placement: _____

Additional Information: _____

_____

_____

_____

Pregnancy

- ❒ Complications: _____
- ❒ Medications taken during pregnancy: _____
- ❒ Prenatal exposure to ❒ alcohol ❒ tobacco ❒ drugs ❒ other: _____
- ❒ Maternal hospitalizations: because of _____
  From _____ weeks gestation to _____ weeks gestation.
- ❒ Breech Position
- ❒ Other: _____

Birth

Name of Hospital: _____ Length of Stay: _____

❒ Full Term ❒ Premature ❒ Post mature _____ Born at weeks gestation age

❒ Vaginal birth ❒ C-section Reason: _____

❒ Difficult Labor_____ ❒ Other: _____

❒ Birth Weight: _____ Apgar Scores: _____

❒ Complications: _____

Neonatal:

❒ NICU Stay Hospital: _____ Length of Stay: _____

❒ Ventilator/Breathing Tube	❒ Difficulty Feeding
❒ Oxygen Tube	❒ Physical Therapy
❒ Retinopathy of Prematurity	❒ Occupational Therapy
❒ Seizures	❒ Speech Therapy

❒ Intraventricular Hemorrhage (IVH) Grade ____

❒ Reflux/Gastroesophageal Reflux Disease (GERD)

❒ Periventricular Leukomalacia (PVL)

❒ Additional Diagnoses: _____

❒ Hearing Screening Results: ❒ Pass ❒ Fail

❒ Vision Screening Results: ❒ Pass ❒ Fail

Current Medical Status

Please tell us all **other doctors or specialists** involved in your child's care:

Specialty of Physician (ENT, GI, Geneticist)	Name of Physician (First and Last)	Date Last Seen	Phone Number(s)	Fax Number
Pediatrician				

MedStar Georgetown University Hospital

Please list all **medical diagnoses** your child has:

Diagnosis	Age at time of Diagnosis	Diagnosing Physician

Please list all **medications** your child takes:

Medication	Dosage	Route (Oral, Nasal)	Frequency	Prescribing Physician	Start Date	Stop Date

Does your child wear glasses or have problems seeing? _____ (Please describe)
Results of last **hearing** evaluation:_____ Date:_____
Results of last **vision** evaluation:_____ Date:_____

Please **list any additional special tests, procedures, and/or hospitalizations/surgical** since birth (MRI, EEG):

Date	Procedure	Reason for Testing	Results of Procedure

Development

Please write the age when your child first performed the following skills (circle months or years)

Sat alone: _____(Months/Years)
Crawled: _____ (Months/Years)
Walked: _____ (Months/Years)
Babbled: _____ (Months/Years)
Used a cup: _____ (Months/Years)
Pulled to stand: ____ (Months/Years)
Toilet-trained: _____ (Months/Years)
Learned to Write: _____(Months/Years)
Said a single word: _____ (Months/Years)
Dressed Self: _____ (Months/Years)
Fed self: _____ (Months/Years)
Used cup: _____(Months/Years)

Does your child use any of the following at home or at school?

❒ Walker ❒ Wheelchair ❒ Special cups/spoons ❒ Pacifier ❒ Sippy cup
❒ Assistive Technology ❒ Infant "walker" or jumper ❒ Infant Swing ❒ Exersaucer
❒ Other: _____

MedStar Georgetown University Hospital

Speech and Language

Please list any speech/language difficulties: _____

_____

Have your child's language skills regressed? (Lost words, no longer follows directions)

_____

Does your child repeat or echo certain words or phrases? _____

_____

Feeding

How does your child currently receive nutrition? Check all that apply:

❒ NG-Tube
❒ Bottle: Brand (e.g., Dr. Brown, Avent) _____
Nipple type (e.g., fast, level 1): _____
❒ Open Cup
❒ Straw
❒ NJ-Tube
❒ G-Tube
❒ Sippy Cup
❒ Spoon/Fork
❒ Hands

If your child receives tube feedings, please complete the following:

❒ Continuous Feeds: _____ cc/hour for _____ hours
Beginning time: _____ Ending Time: _____

❒ Bolus Feeds: _____ cc/oz
Times Given: _____

What foods does your child currently take?

❒ Breast Milk
❒ Formula: _____
Calories (e.g., 28 kcal):_____
❒ Stage 1 Baby Food
❒ Stage 2 Baby Food
❒ Stage 3 Baby Food
❒ Pureed Table Foods
❒ Soft Chewables
❒ Pediasure
❒ Hard Chewables
❒ Chewy foods

List your child's preferred foods/liquids: _____
List your child's non-preferred foods/liquids: _____
How long does a meal (or for infants, a bottle) usually take (e.g., 5 minutes, 1 hour)? _____

Please indicate any known adverse/allergic drug and/or food allergies (e.g., penicillin, latex, gluten):

_____
_____
_____

Does your child display any of the following behaviors related to feeding?

❒Frequent coughing/choking related to feeding

MedStar Georgetown University Hospital

❒ Gagging/vomiting related to feeding
❒ Refusal behaviors (e.g. head turning) related to feeding
❒ Difficulty accepting foods of certain textures
❒ Difficulty chewing
❒ Holding food in mouth
❒ Other (please describe any difficulties related to feeding/swallowing):

_____
_____

Has your child had a swallow study by a speech pathologist? ❒ Yes ❒ No
If yes: Where: _____ When: _____
Results: _____

School or Early Intervention

School or Service:_____City/County_____
Grade:_____ Teacher(s):_____
Support Services: _____ Approximate # of Students in Class: _____

❒ Individual Family Service Plan (IFSP)
❒ Individual Education Plan (IEP)
❒ Adapted PE
❒ Physical therapy
❒ Occupational therapy
❒ Assistive technology
❒ Speech therapy
❒ Classroom aide
❒ Other: _____
❒ Involved in organized activities or sports? _____
❒ Any concerns or difficulties?_____

Behavior

What are your child's favorite activities? _____
What motivates your child? _____
How does child play with brothers and sisters? ❒ Poor ❒ Fair ❒ Well ❒ N/A
How does child play with children his/her own age? ❒ Poor ❒ Fair ❒ Well
What is the length of time your child can attend to an activity? _____
Does your child have any behavior issues? _____
_____
Does your child have any attention difficulties? _____
How many hours per night does your child sleep? _typically 9pm -7am_
Does your child have difficulty falling asleep? ❒ Yes ❒ No
On average, how many times does your child wake up during the night?_____
Does your child self-feed? ❒ Finger ❒ Utensils ❒ Other_____
Does your child have any repetitive behaviors? (Hand flapping, rocking, lining up toys)
_____
Is your child bothered by certain sensations / feelings?
❒ Noises ❒Textures, clothing, or touch ❒ Movements ❒ Lights
Please Specify: _____

Please add any other additional information you would like us to know about your child:
_____
_____

MedStar Georgetown
University Hospital

_____

_____

_____

THIS QUESTIONNAIRE WAS REVIEWED BY:

Therapist's Signature: _____ Date: _____

MedStar Georgetown University Hospital

To Be Completed by Therapist:

Time of Day	Activity (Nap, Play time, Meal)	Duration of Activity	Quality of Activity	Behaviors Noted during Activity
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
10:00 AM				
11:00 AM				
12:30 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				