QUINCY MEDICAL GROUP
Pediatric Therapy

Pediatric Therapy
1101 Maine St, First Floor
Quincy, IL 62301
(217) 222-6550, ext. 3418

Pediatric Feeding History Form

Please fill out the following information for the therapists to identify concerns your child is having with feeding problems at home, school, and in the community. Please feel free to write stories on this paper, highlight certain areas that pertain to your child, and to cross out parts of statement that do not pertain to you child. If you have questions, please call: (217) 222-6550, ext. 3418.

Important Items to Bring:

- Any feeding utensils that are being used and trialed at home (i.e., bottles, nipples, nipple shield, SNS systems, spoons, cups, star cups, sippy cups).
- For children on solid foods: please bring three (3) non-preferred foods (foods the child is unable to eat or refuses to eat) AND three (3) preferred foods (foods the child is able to eat or likes to eat).

Please email your completed forms to pediatrictherapyreception@quincymedgroup.com.
The forms may also be mailed or dropped off at the following address or can be provided at the child's appointment.

Quincy Medical Group
Pediatric Therapy Services
1101 Maine Street
Quincy, IL 62301

A. Identifying Information

Patient Name: _____ Preferred Name: _____

Date of Birth: _____ Referral Source: _____

Reason for Referral: _____

_____

_____

Current Weight: _____ ☐ Ideal ☐ Overweight ☐ Underweight

Current Height: _____

WHO Growth Chart: _____ % Height _____ % Weight

Has your child's growth chart been reviewed with you? ☐ Yes ☐ No

Do you have concerns about your child's growth pattern? ☐ Yes ☐ No

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Patient/Family Goals & Concerns: _____

_____

_____

What would you like your child to eat? _____

_____

_____

What are strong motivators (reinforcers) for your child? (e.g., food, toys, activities)? _____

_____

_____

_____

B. Pertinent Past & Current Medical Information

B1. Medications

Please list medications currently taking: _____

_____

_____

B2. Birth History

Length of Pregnancy: _____ weeks _____ days

Birth Weight: _____ pounds _____ ounces

APGAR Scores: _____ 1 minute _____ 5 minutes _____ 7 minutes

Pregnancy Complications (if so, please describe): _____

_____

_____

_____

Type of Delivery: ☐ Vaginal ☐ Cesarean-Section

Delivery Complications (if so, please describe): _____

_____

_____

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B3. Neurologic History

☐ No history of neurologic issues
☐ Seizures
☐ Brain Tumor
☐ CVA
☐ TIAs
☐ IVH/PVL
☐ Anoxia
☐ Hydrocephalus
☐ Nystagmus
☐ Tremors
☐ Microcephaly
☐ Craniofacial Anomalies
☐ Mixed Muscle Tone
☐ Other: _____
☐ Hypotonia
☐ Hypertonia
☐ Cerebral Palsy
☐ Paralysis
☐ Ataxia
☐ Current neurologic impairment: _____

B4. Cardiac History

☐ No history of cardiac problems
☐ Type of Problem: _____
Related Surgeries: _____

Known Complications from Cardiac Condition:
☐ CVAs
☐ Vocal Fold Paralysis
☐ Other: _____
☐ TIAs
☐ Reduced Endurance/Fatigue

B5. Respiratory/Airway History:

☐ No history of respiratory/airway issues
☐ Pneumonia
☐ Asthma
☐ Stridor
☐ Frequent colds (# per year:_____)
☐ Tracheomalacia
☐ Laryngomalacia
☐ Bronchomalacia
☐ Aspiration Pneumonia
☐ Tracheal Stenosis
☐ Vocal Fold Paralysis
☐ BPD/Bronchopulmonary Dysplasia
☐ Frequent upper respiratory infections (# per year: ____)

B6. Gastrointestinal History

☐ No history of GI issues
☐ Reflux/GERD
☐ Fundoplication
☐ Dehydration
☐ Constipation
☐ Bowel Obstruction
☐ GI Bleeding
☐ Chronic Diarrhea
☐ Failure to Thrive
☐ Other: _____
☐ NG-tube
☐ G-tube
☐ J-tube
☐ GJ tube
☐ PEG tube
☐ Gastroschisis
☐ Pyloromyotomy
☐ Short Bowel Syndrome
☐ Slow Gastric Emptying
☐ Dumping Syndrome
☐ Diabetes
☐ Hypoglycemia
☐ Lactose Intolerance
☐ Celiac Disease
☐ Crohn's Disease
☐ Esophagitis
☐ Eosinophilic Esophagitis

Current Bowel Movement Pattern: ☐ Regular ☐ Diarrhea ☐ Constipated ☐ Inconsistent

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B7. Renal History

☐ No history of renal problems
☐ Acute Renal Failure
☐ Chronic Renal Failure
☐ Dialysis (frequency: _____)

Structural Deviations: _____

Related Surgeries: _____

Food restrictions due to renal problems (e.g., protein, potassium, sodium, fluid, calcium, and phosphorous intake): _____

_____

_____

B8. Craniofacial History

☐ No known defects of the palate
☐ Submucosal Cleft
☐ Cleft Lip (specify: _____)
☐ Cleft Palate (specify:_____)
☐ Dental Abnormalities_____
☐ Retrognathia
☐ Nasal Regurgitation
☐ Other: _____
_____

Date of last dental visit & results: _____

Detailed Surgical History, including dates and success of surgeries:_____

_____

_____

_____

_____

_____

B9. Hemolytic History

☐ No hemolytic disorders
☐ Anemia
☐ Jaundice
☐ Polycythemia
☐ Sepsis
☐ Other: _____

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B10. Allergy History

Food Intolerance: ☐ Soy ☐ Gluten ☐ Milk/Dairy ☐ Egg ☐ Peanut
☐ Other: _____
☐ Other Environmental Allergies: _____
☐ Other Drug Allergies: _____

Dietary Preferences (Kosher, gluten free, etc.): _____

_____

B11. Medical Providers

Has your child seen a nutritionist or dietitian?
☐ No ☐ Yes (if yes, list their recommendations): _____

_____

Please list other specialists who provide care to your child:
Name: _____ Specialty: _____
Name: _____ Specialty: _____
Name: _____ Specialty: _____
Name: _____ Specialty: _____
Name: _____ Specialty: _____

C. Swallowing & Feeding History

C1. Nipple Feeding Status & History

Current Diet: _____

How was your child fed as an infant? ☐ Breast ☐ Bottle ☐ Tube

Bottle/Nipple used for non-breast feeding: _____

Volume (daily intake): ☐ Formula: _____
☐ Breast Milk: _____
☐ Water: _____

Use of Additive/Nutritional Supplement: ☐ No ☐ Yes (name of supplement, list of all trialed):

_____

Age child transitioned to bottle: _____
Age child transitioned to cup: _____
Age child transitioned to eating from a spoon: _____

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Describe any difficulties your child experienced with feeding as an infant (sucking, weight gain, sleep cycles, temperament):_____

_____

_____

_____

_____

C2. Breastfeeding History

Length of Time:_____ Reason for Weaning: _____

Infant's Response during Nursing:

☐ Vigorous ☐ Lethargic ☐ Fussy ☐ Quiet ☐ Comfortable ☐ Variable

Mother's Perception of Breastfeeding: _____

_____

_____

_____

C3. Alternate Nutrition

☐ TPN (Start Date/End Date): _____

External Feeds: ☐ Nasogastric Tube ☐ Gastrostomy Tube
Type of Feeding: ☐ Bolus/Gavage ☐ Continuous Drip

Current product for tube feeding:

_____

Current rate:

_____

Current schedule:

_____

Typical positioning during feeding: _____

Adverse behaviors during tube feeding:

☐ Gagging	☐ Hiccups	☐ Wet burps	☐ Spit up
☐ Regurgitation	☐ Frequent burping	☐ Sweat	☐ Lethargic
☐ Nasal regurgitation	☐ Retch	☐ Scream	☐ Arch back

☐ Other: _____

If your child has reflux, have you ever noted coughing or a gurgly voice after the episode? ☐ Yes ☐ No

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C4. Diagnostic Procedures:

Diagnostic Procedures Completed (Date & Results):

☐ MBC/VFSS: _____

☐ FEES: _____

☐ pH/Impedance Probe: _____

☐ Upper GI: _____

☐ Endoscopy: _____

☐ Gastric Emptying/Milk Scan: _____

☐ Genetic Testing: _____

☐ Allergy Testing: _____

☐ Other: _____

D. Current Environment & Performance Factors

D1. Environmental Factors

List family members present during mealtimes: _____

_____

_____

Typical feeding schedule: _____

_____

_____

Length of average mealtimes: ☐ < 5 minutes ☐ 5-20 minutes` ☐ > 30 minutes

Are there distractions during mealtime (i.e. TV, iPad)?
☐ No ☐ Yes (please describe): _____

Does your child eat more/ less when they are in different environments? (home versus school or grandparents' house)?
☐ No ☐ Yes (please describe) _____

Current position for feeding:

☐ Supine (on back)	☐ Adult Chair	☐ Kneeling in Chair	☐ Feet supported by footrest
☐ Side-lying	☐ Child Chair	☐ Standing	☐ Feet suspended above floor
☐ Elevated	☐ Booster Seat	☐ Other: _____	

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D2. Child Performance Factors

Does your child feed themselves? ☐ Yes ☐ No

What utensils are used? ☐ Fork ☐ Spoon ☐ Fingers

Does your child enjoy eating? ☐ Yes ☐ No

Does your child exhibit difficulty with any of the following during mealtime?

☐ Drooling
☐ Biting (able to bite piece off food)
☐ Chewing
☐ Teeth grinding
☐ Swallowing
☐ Continuous sucking/poor sucking
☐ Chewing
☐ Lip control
☐ Tongue control (tongue thrust, poor mobility)
☐ Hypersensitivity to textures, temperatures, utensil use
☐ Coughing
☐ Gagging
☐ Vomiting/regurgitation
☐ Other: _____

Does your child exhibit any of the following behaviors during mealtime?

☐ Messy eater
☐ Throws food
☐ Spits food
☐ Holds food in mouth
☐ Overeats (stuffs mouth)
☐ Cries/screams
☐ Only eats certain foods
☐ Refuses food
☐ Vomits
☐ Gags/coughs
☐ Takes food from others
☐ Tries to get out of eating
☐ Falls asleep or fatigues with meals
☐ Leave table before finishing
☐ Other: _____

Food/liquid temperature preferences: ☐ Warmed ☐ Chilled ☐ Variable

<u>Food consistency (check all that currently applicable):</u>

Liquids/soups:
☐ Does eat ☐ Can eat ☐ Never eats ☐ Refuses ☐ Not tried

Baby food:
☐ Does eat ☐ Can eat ☐ Never eats ☐ Refuses ☐ Not tried

Creamy foods (ice cream, yogurt):
☐ Does eat ☐ Can eat ☐ Never eats ☐ Refuses ☐ Not tried

Blended/pureed table food:
☐ Does eat ☐ Can eat ☐ Never eats ☐ Refuses ☐ Not tried

Mashed table food:
☐ Does eat ☐ Can eat ☐ Never eats ☐ Refuses ☐ Not tried

Chopped table food:
☐ Does eat ☐ Can eat ☐ Never eats ☐ Refuses ☐ Not tried

Regular table food:
☐ Does eat ☐ Can eat ☐ Never eats ☐ Refuses ☐ Not tried

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Soft table food (pancakes):
☐ Does eat ☐ Can eat ☐ Never eats ☐ Refuses ☐ Not tried

Crisp foods (crackers, toast):
☐ Does eat ☐ Can eat ☐ Never eats ☐ Refuses ☐ Not tried

Chewy foods (meat):
☐ Does eat ☐ Can eat ☐ Never eats ☐ Refuses ☐ Not tried

Crunchy foods (carrots, celery, pretzels):
☐ Does eat ☐ Can eat ☐ Never eats ☐ Refuses ☐ Not tried

List any foods consistently accepted in the following categories:

Fruits: _____

Meats: _____

Breads/Cereals: _____

Vegetables: _____

Dairy Products: _____

Sweets: _____

Snacks: _____

Beverages: _____

Please provide other comments you would like to share about your child's eating habits:

_____

_____

_____

_____

_____

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D3. Parent/Caregiver Performance Factors

Do you consider yourself a picky eater? ☐ Yes ☐ No
Do you eat fruits and vegetables? ☐ Yes ☐ No
Do you consume a variety of food groups? ☐ Yes ☐ No

Can you determine when your child is hungry?
☐ No ☐ Yes (if so, how?) _____
Can you determine when your child is full?
☐ No ☐ Yes (if so, how?) _____

Describe the sequence in which food is offered to your child (e.g., liquids always first, etc.)

_____
_____
_____

As a parent, what strategies or techniques have you been trying independently to assist your child in eating? What do you do when your child does not eat appropriately?

_____
_____
_____
_____
_____
_____
_____
_____

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Three Day Diet History Form

Instructions:
You are being asked to record **ALL foods and drinks** consumed by your child for three consecutive days. The following directions will guide you in filling out the form. You will need to complete this history and bring it to the child's appointment at Quincy Medical Group Pediatric Therapy Services with the rest of this completed packet.

1. Please fill out **ALL** the information at the top of the first page of the diet form

2. Please record the **DATE** and **DAY** of the week for each day at the top of each table. Record **ALL** food and drinks eaten along with the **TIME** your child ate or drank them. It is best to carry the history from with you and to record items immediately so that nothing is missed.

3. Include an **EXACT** description of the item and your best guess of the portion size of the amount eaten. Write the brand name of formula (if this pertains to you) your child is on (i.e. Enfamil, Prosobee, etc), what type of juice he/she drank (i.e. apple, grape, etc), any special recipes for drink mixtures your child uses (i.e. 24 calories Isomil + 1tsp Polycose), and any additions to foods (i.e. ¼ cup mashed potatoes + 1 Tbsp margarine). Be sure to include dressings, sauces, gravies, or anything extra.

4. It is suggested that you may wish to use measuring spoons and cups when serving your child for these three days to report the amounts consumed better.

Example:

Date: 6/10/2024 Day: Wednesday

Time	Food/Drink Item	Amount	Bottle	Cup	Mouth	G-Tube
4 pm	Gerber applesauce #2	1 ounce			✓	
	White bread (Wonder)	¼ slice			✓	
	Ham lunch meat (Hormel)	½ ounce			✓	
	Mayonnaise	1 tsp			✓	
	White grape juice	1 ounce		✓	✓	

Please email your completed forms to **pediatrictherapyreception@quincymedgroup.com.**
The forms may also be mailed or dropped off at the following address or can be provided at the child's appointment.

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1101 Maine Street
Quincy, IL 62301

Questions? (217) 222-6550, ext. 3418

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Three Day Diet Log

Parent/Caregiver Name: _____

Daytime Phone #: _____

Child's Name: _____ Date of Birth: _____

Vitamin or Mineral Supplement: ☐ Yes ☐ No

Name & Amount: _____

Formula Mixing: Number of scoops: _____ Amount of water: _____

☐ I put the water in the bottle first, then the formula powder
☐ I put the formula powder in the bottle first, then the water
☐ The formula is liquid in a can, and I do not add anything.

Date: _____ Day: _____

Time	Food/Drink Item	Amount	Bottle	Cup	Mouth	G-Tube

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Date: _____ Day:_____

Time	Food/Drink Item	Amount	Bottle	Cup	Mouth	G-Tube

Date: _____ Day:_____

Time	Food/Drink Item	Amount	Bottle	Cup	Mouth	G-Tube

Please email your completed forms to pediatrictherapyreception@quincymedgroup.com.