Kid Talk
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FEEDING AND SWALLOWING CASE HISTORY

Kid Talk requests this information for the sole purpose of completing a thorough evaluation on your child. Completion of this form is required prior to your scheduled evaluation.

GENERAL INFORMATION

Child's Name:	Date of Birth:	Age:
Person Providing the Information:	Today's Date:	Sex:
Child's Address:	Phone Number: Cell Phone Number:	Insurance Plan:
Physician:	Clinic:	Referred By:

FAMILY INFORMATION

Father's Name:	Occupation:
Mother's Name:	Occupation:
Are parents (circle one): Married Separated Divorced Remarried	Please list siblings living at home and ages:
Is your child adopted or a foster child? If so, at what age and from where?	Have there been any instances of the following in the immediate or extended family? o Autism/PDD o ADHD o Learning Disabilities o Speech/Language Delays o Feeding Difficulties

PREGNANCY AND BIRTH HISTORY

(please check appropriate box)	Yes	No	COMMENTS
1. Were there any illnesses, injury, bleeding, or any complications during the pregnancy?	Yes	No	
2. Was this pregnancy full-term? If not, please give gestational age.	Yes	No	
3. Were any drugs or medications taken during this pregnancy? If so please list.	Yes	No	
4. Was labor and delivery normal?	Yes	No	
5. Please list birth weight and length.	Yes	No	
6. What was your method of delivery (vaginal, breech, or cesarean)? Were forceps/suction used?	Yes	No	
7. Was oxygen or respiratory assistance required after birth?	Yes	No	
8. Did your child have normal weight gain as an infant? , sleeping cycles, and temperament?	Yes	No	
9. Did your child have normal sleeping cycles as an infant?	Yes	No	
10. Did your child have a normal temperament as an infant?	Yes	No	

MEDICAL HISTORY

Has your child experienced any of the following? (please check appropriate box)	Yes	No	
a. Tonsil/adenoid problems	Yes	No	
b. Congenital defects	Yes	No	
c. Seizures	Yes	No	
d. Frequent ear infections or fluid in the ears	Yes	No	
e. PE tubes (if so when and by whom)	Yes	No	
f. Cleft Palate/Lip	Yes	No	
g. Gastroesophageal Reflux	Yes	No	
h. Failure to Thrive	Yes	No	
i. History of respiratory illness? (i.e. pneumonia/RSV)	Yes	No	
j. Issues with constipation or	Yes	No	

diarrhea? How frequently?			
k. Any blood in the stools?	Yes	No	
l. Heart Problems	Yes	No	
m. Headaches	Yes	No	
n. Snores or breathes through the mouth	Yes	No	
o. Diabetes	Yes	No	
p. Rashes/eczema	Yes	No	
q. Sleep issues	Yes	No	
Is your child currently taking any medications? If so please list.	Yes	No	
Does your child take any nutritional supplements? (product, amount, frequency)	Yes	No	
Has your child lost or gained any weight in the last 6 months, and how much?	Yes	No	
Would you describe your child's weight as (circle one):	Ideal	Underweight	Overweight
Has your child has any food and/or environmental allergy testing completed? (please circle one)	Yes	No	IgG mediated IgE mediated I am unsure
Based on test results does your child have food allergy/sensitivity?	Yes	No	If yes, please list and specify whether allergy or sensitivity and severity (i.e., severe food allergy to peanuts).
Based on test results does your child have an environmental allergy?	Yes	No	If yes, please list and specify severity of allergy (i.e., severe allergy to ragweed).
If your child has had food allergy testing completed and it came back normal do you feel that your child is sensitive/intolerant of some foods?	Yes	No	Please list and give symptoms.
Do other family members have any food or environmental allergies?			Please List:
Are there any other medical concerns? If so, please describe.	Yes	No	
Has your child ever been hospitalized? If so, when and for what?	Yes	No	
Are there any other precautions we should know about that are not described above?	Yes	No	If so, please describe.

DEVELOPMENTAL MILESTONES

1. At what age did your child:	Age/Comments
a. sit independently?	
b. crawl?	
c. walk independently?	
d. speak first word?	
e. produce 2 word combinations?	
h. drink from a cup?	
i. use a spoon?	
l. potty trained?	

FEEDING AND SWALLOWING HISTORY

What is your primary concern regarding your child's feeding?	Please explain in detail.		
When did you first notice a problem?	Please explain in detail.		
How has the problem changed since you first noticed it? (i.e., remained the same, worsened, improved)			
What types of techniques have you tried at home?			
Was your child breast fed? For how long?	Yes	No	
Was your child bottle fed? For how long?	Yes	No	
Were there difficulties with breast or bottle feeding? (e.g. initial skill, poor suck, slow to feed, fatigue)	Please explain in detail.		
Please list all formulas and your child has taken from birth to current. List approximate ages they were taking each formula.			
Which formula seemed to work best for your child?			
What symptoms did/does your child exhibit that made you either put your child on formula or change to a different formula.			
Was or is your child fed through a feeding	Yes	No	For how long?

tube?			What were they fed?
At what age were pureed foods introduced?			
Any difficulty with eating or transitioning to pureed foods?	Yes	No	□ gas □ bloating □ gagging □ vomiting □ decreased intake □ crying
At what age were regular table foods introduced?	Yes	No	
Any difficulty with eating or transitioning to regular table foods?	Yes	No	□ gas □ bloating □ gagging □ vomiting □ decreased intake □ crying
Any difficulty with drinking liquids?	Yes	No	□ gas □ bloating □ gagging □ vomiting □ decreased intake □ crying
How is your child usually positioned during feeding? (please check the position that is most frequently used)	o Held on the lap o Infant seat o Booster seat o Sitting in a wheelchair o Sitting in a chair at the table o Lying down o High chair o Floor		
How long does it take your child to complete a meal?	o Less than 10 minutes o 10-20 minutes o 20-30 minutes o Over 30 minutes		
Does your child eat or drink constantly throughout the day?	Yes	No	If so what does he eat?
How many ounces of liquid does your child take in a 24-hour period?	Please be specific (i.e., cups/ounces). o Water: o Juice: o Milk: o Supplement: o Other:		
In relation to a mealtime when is liquid given?	o **Water:** Before During After Sucks/Drinks all day o **Juice:** Before During After Sucks/Drinks juice all day o **Milk:** Before During After Sucks/Drinks juice all day o **Supplement:** Before During After Sucks/Drinks juice all day o **Other:** Before During After Sucks/Drinks juice all day		

Are mealtimes pleasant?	Yes	No	
Describe the environment during a mealtime. (i.e. noisy, quiet, distracting)			
Who is present for mealtime?			
Does your child eat/drink better when siblings or peers are present?	Yes	No	
What seems to help (or not help) during mealtime?			
Does your child feed himself/herself? If no, who typically feeds your child?	Yes	No	
Other than parents, who else feeds your child? How frequently and in what setting? How does your child respond when others feed him/her?			
Is adaptive equipment used during feeding? If yes, please specify.	Yes	No	
What utensils are usually used and at what age were they introduced?	Bottle_____ Fingers _____ Straw_____ Other_____ Fork _____	Spoon _____ Sippy cup _____ Cup with lid _____ Open cup _____	
How do you know when your child is hungry?			
How do you know when your child is full?			

Please check those that apply to your child:

- Eats too much
- Choking during meal
- Food or liquid coming out of the nose
- Difficulty swallowing
- Trouble breathing during feeding
- Spitting food out
- Throwing food
- Stiffening during feeding
- Eats too little
- Gagging during a meal
- Crying/screaming during meals
- Reflux during/after meals
- Vomitting during/after meals
- Holding food in his/her mouth
- Refuses oral feeding
- Dislikes being touched by the mouth
- Eats frequently throughout the day
- Eats/drinks while in the car

- Hyperextending during feeding
- Noisy breathing: During, before, or after feeding
- Gurgly vocal quality: During before, or after feeding
- Color change with meals (pale, gray)
- Fatigues with meals
- Getting down from table during meal
- "Picky" eater
- Complains of food getting stuck in throat
- Complains of stomach aches before/during/after meals
- Eats with mouth open
- Sticks tongue out while eating/swallowing
- Eats a balanced diet

How much does your child drool?	○ Never ○ Rarely ○ Occasionally ○ Frequently ○ Constantly		
Do you feel your child likes to eat?	Yes	No	
Please describe any other feeding problems that your child is experiencing?			
Please provide the names, dates you saw provider and contact information for any other providers who you have seen to address this feeding issue (i.e., dietician, functional medicine physician. Naturopath)			