KVH
Kittitas Valley Healthcare
Speech Therapy
Your Home for Health

Pediatric Feeding History

Patient Name _____ Date of Birth ___/___/___

Parents' Names _____ _____

Medical and Developmental History

Pregnancy and birth history _____

_____

Health history _____

_____

_____

Current medications _____

_____

Known Allergies _____

Early developmental milestones *(sat alone, crawled, walked, babbled, self-fed, etc.)* _____

_____

_____

Past or current therapies *(list disciplines, facility, and therapist name)* _____

_____

_____

Does your child have any extra sensory needs/avoidances? *(noise, texture, lights, etc.)* _____

_____

_____

Describe any difficulties with feeding your child had as an infant *(sucking, weight gain reflux, etc.)*

_____

_____

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

How long did your child receive breast milk? _____ Formula? _____

What type of formula(s) did you use? _____

At what age did you introduce:

- Pureed solids _____
- Easily dissolvable solids (puffs) _____
- Table foods _____
- Spoon feeding _____

Describe any difficulties with transitioning from bottle to finger foods/spoon feeding.

_____

_____

Current Feeding Concerns

Child's weight _____ Child's height _____

Describe any concerns with your child's weight/height. _____

Is your child on a special diet? (gluten-free, dairy-free, etc.) _____

Does your child take any nutritional supplements? (List product and frequency)

_____

Has your child seen a nutritionist or dietician? If so, who, and what were the recommendations?

_____

_____

_____

_____

Does your child experience difficulty with any of the following during meal time?

☐ Drooling
☐ Teeth grinding
☐ Food/liquid coming out of nose
☐ Chewing
☐ Continuous or poor sucking
☐ Gagging
☐ Swallowing
☐ Biting (inability to bite pieces off food)
☐ Coughing
☐ Vomiting/regurgitation
☐ Lip control (keeping mouth closed, food in mouth)
☐ Other (please specify)
☐ Hypersensitivity (texture/temperature)
☐ Tongue control (tongue thrust/poor mobility)

Does your child exhibit any of the following behaviors during meal time?

☐Throws food	☐Refuses food	☐Spits out food
☐Messy eater	☐Cries/screams	☐Leaves table before finished
☐Only eats certain foods	☐Overeats (stuffs mouth)	☐Gags/coughs
☐Holds food in mouth	☐Vomits	☐Fatigues with meals

☐Other (please specify) _____

How is your child seated during meal time?

☐Regular chair ☐High chair ☐Booster seat ☐Standing ☐Other: _____

Are their feet supported while eating? ☐Yes ☐No

Does your child feed themselves? ☐Yes ☐No

What utensils are used? ☐Fork ☐Spoon ☐Fingers

How are liquids presented? ☐Bottle ☐Regular cup ☐Sippy cup ☐Straw ☐Other _____

How do you know when your child is hungry? _____

How do you know when your child is full? _____

How many times a day does your child eat? (include snacks) _____

How long does it take for your child to complete a meal? _____

Does your child eat more/less in different environments? _____

Do you feel your child likes to eat? ☐Yes ☐No

Describe how foods/liquids are presented at meals: _____

_____

As a parent, what strategies or techniques have you been trying independently to assist your child in eating? What happens when your child has challenging behaviors at meal time?

_____

_____

_____

Food Consistency | Check all that are currently applicable:

	Does eat	Can eat	Never eats	Can't eat	Refuses	Not tried
Liquids/soups	☐	☐	☐	☐	☐	☐
Baby food	☐	☐	☐	☐	☐	☐
Creamy foods (ice cream, yogurt)	☐	☐	☐	☐	☐	☐
Blended/pureed table food	☐	☐	☐	☐	☐	☐
Mashed table food	☐	☐	☐	☐	☐	☐
Chopped table food	☐	☐	☐	☐	☐	☐
Regular table food	☐	☐	☐	☐	☐	☐
Soft table food	☐	☐	☐	☐	☐	☐
Crisp food	☐	☐	☐	☐	☐	☐
Chewy food	☐	☐	☐	☐	☐	☐
Crunchy food	☐	☐	☐	☐	☐	☐

List any foods your child consistently eats in the following categories:

Fruits _____

Meats _____

Breads/cereals _____

Vegetables _____

Dairy products _____

Sweets _____

Snacks _____

What would you like your child to eat? _____

_____

Is there anything else you would like me to know about your child? _____

_____

_____

_____

Additional information for evaluation

Complete the 3-day food log

Please bring 1) a photo of your child in their meal time chair, and 2) a short video of a meal, to reference during evaluation