12121 Wilshire Boulevard, Suite 314 Los Angeles, CA 90025 / 310-739-9337 / admin@lisakleinspeech.com / www.lisakleinspeech.com

FEEDING CASE HISTORY

PATIENT INFORMATION

Patient Name:
Date:
Person filling out questionnaire:
Relationship to Patient:

BIRTH HISTORY

At how many weeks was your child born?
What was your child's birth weight?
How many days were you and your child in the hospital?
Please describe your child's delivery (natural, caesarian, etc):
Please describe your child's conception (natural, IVF, etc):
Did your child have any feeding issues in the hospital? Yes ▢ No ▢ If yes, please explain:
Did your child have any breathing issues in the hospital? Yes ▢ No ▢ If yes, please explain:

DEVELOPMENTAL HISTORY

At what age did your child:

ACTIVITY	AGE	ACTIVITY	AGE
Smile:		Colors:	
Hold head up:		Count:	
Roll over:		Alphabet:	

12121 Wilshire Boulevard, Suite 314 Los Angeles, CA 90025 / 310-739-9337 / admin@lisakleinspeech.com / www.lisakleinspeech.com

Reach for an object:		Demonstrate handedness:	
Transfer an object:		Bladder trained (days):	
Sit:		Bowel trained:	
Crawled:		Eat with utensils:	
Stood alone:		First words:	
Walked:		1-step derivatives:	
Run:		2-word phrases:	

FEEDING HISTORY

Describe in your own words what problem your child is having with feeding:

Was your child breast-fed? Yes ▢ No ▢
If yes, from when to when?

Was your child bottle-fed? Yes ▢ No ▢
If yes, from when to when:

Please describe your child's initial skill on the breast and/or bottle?

During feedings, did your child have any issues with arching? Yes ▢ No ▢
If yes, please describe when, why and for how long:

During feedings, did your child have any issues with crying? Yes ▢ No ▢
If yes, please describe when, why and for how long:

During feedings, did your child have any issues with sitting-up? Yes ▢ No ▢
If yes, please describe when, why and for how long:

During feedings, did your child have any issues with gagging? Yes ▢ No ▢
If yes, please describe when, why and for how long:

During feedings, did your child have any issues with coughing? Yes ▢ No ▢
If yes, please describe when, why and for how long:

Is your child receiving services? Yes ▢ No ▢
If yes, what type and how frequent:

12121 Wilshire Boulevard, Suite 314 Los Angeles, CA 90025 / 310-739-9337 / admin@lisakleinspeech.com / www.lisakleinspeech.com

Is your child still breast and/or bottle-fed? Yes ▢ No ▢ If no, please describe the weaning process and why the child was weaned:
Does your child use a cup? Yes ▢ No ▢ If yes, what kind?
What age did your child begin baby cereal? Please describe if there were any difficulties during this transition.
What age did your child begin baby food? Please describe if there were any difficulties during this transition.
What age did your child begin finger foods? Please describe if there were any difficulties during this transition.
What age did your child begin table foods? Please describe if there were any difficulties during this transition.
If your child is not currently eating table food, please describe why:
List the foods that your child currently will eat and drink. Put a star next to their favorites.
List the foods that your child refuses to eat and drink.
When provided with a food your child dislikes, how does your child respond?
List all the foods your child is allergic to.

12121 Wilshire Boulevard, Suite 314 Los Angeles, CA 90025 / 310-739-9337 / admin@lisakleinspeech.com / www.lisakleinspeech.com

Is your child on a special diet? Yes ▢ No ▢
If yes, what type and when was it initiated?

Who typically feeds your child?

Who typically eats with your child?

What type of chair is used?

Is there a footrest on the chair?

How long do meals last typically?

Does your child use utensils or any type of special cups/bowls, etc? Yes ▢ No ▢
If yes, please describe:

Does your child constantly move/kick feet during meals? Yes ▢ No ▢
If yes, please describe:

What times does your child typically eat and what? Please fill in time and check all that apply.

EATING TIMES	BOTTLE	BREAST	SOLIDS

How do you know if your child is hungry or full?

Has your child lost or gained any weight in the last 6 months? Yes ▢ No ▢
If yes, how much:

Would you describe your child's weight as: Ideal ▢ Underweight ▢ Overweight ▢

Does your child have/had dental problems? Yes ▢ No ▢
If yes, please describe:

12121 Wilshire Boulevard, Suite 314 Los Angeles, CA 90025 / 310-739-9337 / admin@lisakleinspeech.com / www.lisakleinspeech.com

Does your child have/had frequent constipation problems? Yes ▢ No ▢ If yes, please describe:
Does your child have/had frequent diarrhea problems? Yes ▢ No ▢ If yes, please describe:
Does your child have/had vomiting problems? Yes ▢ No ▢ If yes, please describe:
Does your child have/had choking problems? Yes ▢ No ▢ If yes, please describe:
Does your child have/had gagging problems? Yes ▢ No ▢ If yes, please describe:
Does your child have/had coughing problems? Yes ▢ No ▢ If yes, please describe:
Does your child take a vitamin supplement? Yes ▢ No ▢ If yes, which one:
Describe how you and your child feel after a feeding: You: Your child:
What other evaluations/specialties have you seen regarding your child's feeding difficulties and what were the results? Who was the specialist seen?
What treatments have been tried for this problem and what were the results?
What school is your child attending?
With what frequency does your child attend school?
Is your school assisting in any way with your child's difficulties?

12121 Wilshire Boulevard, Suite 314 Los Angeles, CA 90025 / 310-739-9337 / admin@lisakleinspeech.com / www.lisakleinspeech.com

How can we be most helpful to you and your child?

SENSORY HISTORY

For each question, place a check yes or no in the column that best describes your child. Compare with other children you know of the same age.

TACTILE SENSATION	**YES**	**NO**
Does your child seem sensitive to certain fabrics and avoid wearing clothes made of them?		
Have trouble changing to new types of clothing when seasons change? (i.e. from long pants to shorts)		
Avoid going barefoot? (i.e. in sand or grass)		
Become irritated by tags on clothing?		
Seem to crave being held or cuddled?		
Express discomfort when touched by other people, even as in a friendly hug or pat?		
Tend to bump or push others?		
Seem overly sensitive to pain? (i.e. especially bothered by small cuts)		
Seem less sensitive to pain than others? (i.e. to falls and bruises)		
Mouth objects or clothing often?		
Have difficulty judging how much strength to use? (i.e. when petting animals may use too much force)		

GUSTATORY SENSATION	**YES**	**NO**
Act as though all food tastes the same?		
Explore by tasting?		
Dislike goods of certain texture?		
Chew or lick non-food items?		

OLFACTORY SENSATION	**YES**	**NO**
Explore objects by smelling them?		

12121 Wilshire Boulevard, Suite 314 Los Angeles, CA 90025 / 310-739-9337 / admin@lisakleinspeech.com / www.lisakleinspeech.com

Discriminate odors?		
React defensively to smell?		
Seem bothered by smells that most other people don't notice?		

VISUAL SENSATION	**YES**	**NO**
Become easily distracted by visual stimulation?		
Express discomfort at bright lights?		
Avoid or have difficulty with eye contact?		
Have a hard time picking out a single object from many? (i.e. finding a specific toy in the toy box)		
Have difficulty with a camera flash, seems irritated by it?		

FEEDING	**YES**	**NO**
Need assistance to feed him/herself?		
Tend to eat in a sloppy manner?		
Frequently spill liquids?		
Have trouble chewing?		
Have trouble swallowing?		
Have difficulty eating foods with lumps?		
Stuff or put too much food in his/her mouth?		