ECKELMANN-TAYLOR
SPEECH AND HEARING CLINIC
Illinois State University

Child Case History Form Feeding/Swallowing

Name ______________________________ Date ______________

Date-of-Birth ______________ Age __________

School ______________ Grade __________

Native Language ______________________ Primary Language ______________________

Mother's Name ______________________ Father's Name ______________________

Address ______________________ Address (if different) ______________________

______________________ ______________________

Phone ______________________ Phone ______________________

Home Work Cell (CIRCLE ONE) Home Work Cell (CIRCLE ONE)

Alernate Phone ______________________ Alternate Phone ______________________

Home Work Cell (CIRCLE ONE) Home Work Cell (CIRCLE ONE)

Email Address ______________________ Email Address ______________________

Person Completing Form ______________________________

Physician's Name ______________________ Phone ______________________

Referred by ______________________________

Please answer the following questions as thoroughly as possible

1. Birth weight ______________________________
2. Birth complications ______________________________
3. Diagnosis ______________________________
4. Primary caregiver(s) ______________________________
5. Other children in the home ______________________________
6. Does your child have: Allergies? ______________ Asthma? ______________

   Other medical complications? ______________________________

FEEDING HISTORY

7. In infancy, child was _________ (breast fed, bottle fed, tube fed). If tube fed, why and for how long?

   ____
8. Was he/she on a ventilator? _________ If yes, how long? ______________________
9. How long did early feedings last? ______________________________
10. Were any strategies (i.e., positioning, external jaw/cheek support, different bottles, nipples, etc.) used to help with early feeding?

    If so, please explain ______________________________

If your child is fed orally,

11. When did he/she transition from formula/breast milk/Pediasure, etc. to baby foods (pureed)? ______
12. When did he/she transition to textured foods? ______
13. When did he/she transition to soft solids? ______
14. When did he/she transition to solid foods? ______
15. What is his/her current diet? (Please provide amounts and types of a typical day's intake-both orally and by tube)

______

______

______

16. Check the following descriptions of behaviors/actions that are consistently exhibited (at least once per week) at the mealtime

☐ a poor appetite
☐ food refusal
☐ talks with mouth full
☐ vomiting
☐ unusual food habits
☐ excessive overeating
☐ whining or fussing at
☐ requests for non-served foods
☐ gets out of seat
☐ throws food
☐ has ability, but doesn't use napkin
☐ poor eye contact with communication partner or feeder
☐ eats too fast
☐ doesn't orient to feeder, but orients at other times
☐ takes bites that are too large
☐ talks too much at mealtime
☐ drinks too fast
☐ chews with mouth open
☐ disinterest in food
☐ extreme food "pickiness"
☐ gagging with or without
☐ mealtime tantrums
☐ food-texture selectivity
☐ yells
☐ mealtimes
☐ takes food from another's tray/plate
☐ easily distracted from eating
☐ "messy" eating; frequent spills
☐ prefers liquids over solid food
☐ doesn't keep hands to self
☐ eats too slow
☐ expelling of food
☐ exhibits self-stimulatory behavior at mealtime
☐ takes bites that are too small
☐ ignores communication partner/feeder

17. Check the following reactions that have been observed with eating

☐ Coughing:
How often per week, month, etc.? ______

☐ Gagging:
How often per week, month, etc.? ______

☐ Slow eating:
How often per week, month, etc.? ______

☐ Choking:
How often per week, month, etc.? ______

☐ Wet vocal quality:
How often per week, month, etc.? ______

☐ Noisy breathing associated with feeding How often per week, month, etc.? ______

☐ Upper respiratory infections, pneumonias, etc How often in the past year? ______

☐ Other physical signs associated with eating (i.e., heart rate, color changes, respiratory changes, weight loss, etc):

Describe what has been observed and how often it has occurred in the past year ______

______

☐ Hospitalizations in the past year? Why? How long? ______

18. What is your child's current weight & height (if known)? ______

Feeding Preferences and Current Practices

19. What is your child's preferred temperature for liquids? ______

For foods traditionally served warm? ______

For foods traditionally served cold? ______

20. Does your child prefer foods:

With strong tastes? ______

With bland tastes? ______

Both? ______

21. Please list 4-5 of your child's favorite foods ______

______

22. Please list 4-5 foods your child doesn't like ______

______

23. Is your child's food modified for him/her (i.e., chopped, ground, pureed, etc.)? If so, please explain ______

______

24. Does your child receive any vitamin/mineral supplements? If so, please describe ______

______

25. Does your child use any particular bowls, utensils, cups, etc? If so, please describe ______

______

26. Does your child sit in a special chair for meals?______ If so, please describe ______

______

27. Does your child "help" with self-feeding?______

With utensils?______

With fingers?______

28. Does your child feed himself/herself? ______

29. Is your child fed by others nearly 100% of the time? ______

Communication

30. Is your child's primary mode of communication:

Verbal? ______

Facial expressions? ______

Vocalizations? ______

Points/gestures? ______

AAC devices? ______

Other? ______

31. What are your goals for your child related to feeding/swallowing? ______

______

32. What are your primary concerns for your child related to feeding/swallowing? ______

______

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