Bacharach
INSTITUTE FOR REHABILITATION

PEDIATRIC FEEDING HISTORY FORM

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

1. Please explain, is your own words, what your child's current feeding problem is:

2. Was your child breast fed? From when to when _____

   Was your child bottle fed? From when to when _____

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

3. During these early feedings, did your child frequently arch, cry, spit up, gag, cough, vomit or pull off the nipple? Circle the behaviors shown and describe when they would happen, and why, and for how long:

4. Describe how the weaning process off the breast and/or bottle went and why the child was weaned:

5. At what age was your child introduced to Baby cereal? _____ Baby food? _____

   Finger foods? _____ Table food? _____

When did they Transition fully to table food? _____

Please describe how these transitions were handled by your child, especially if any difficulties happened:

IF YOUR CHILD EATS BY MOUTH, PLEASE ANSWER THE FOLLOWING QUESTIONS:

6a. List the foods that your child currently will eat and drink (put a star next to their favorites):

6b. List the foods your child refuses:

6c. List the foods your child is allergic to:

6d. Describe your child's mealtime:

Who typically feeds your child? _____

Who typically eats with your child? _____

What type of chair is used? _____

How long are meals typically? _____

Does your child use utensils or any type of special cups/bowls (describe)? _____

Are there any other activities going on at meals? What activities (describe)? _____

6e. What times does your child typically eat and what type (bottle, breast, solids)?

Time	Breast	Bottle	Solids (baby food; table?)

IF YOUR CHILD IS *TUBE FED*, PLEASE ANSWER THE FOLLOWING QUESTIONS:

7a. What type of formula is used and exactly how do you mix it?

7b. Describe where your child is tube fed and what activities are occurring at the same time:

7c. Describe your child's reactions to the tube feedings (connecting, during, disconnecting):

7d. Please detail your child's feeding schedule below.

Time of feeding (start time)	NG, G or Continuous	Amount	Gravity or Pump	Over what time period or what rate

*PLEASE ANSWER FOR ALL CHILDREN

8. Has your child ever been on any type of special diet other than what you just described (circle 1)? **YES NO**
   If yes, please describe type of diet, at what ages, why and what was your child's response:

9. How do you know your child is hungry or full?
   Hungry?

   Full?

10. Has your child lost or gained any weight in the last 6 months, and how much?

11. Would you describe your child's weight as (circle one): Ideal Underweight Overweight

12. Does your child have/had any of the following problems (circle which ones)? Please describe:
    Dental, frequent constipation, frequent diarrhea, vomiting, choking, gagging, coughing

13. Does your child take a vitamin supplement? Which one?

14. Describe how you, and your child feel after a feeding:
    You:

    Your child:

15. What other evaluations have been completed regarding your child's feeding difficulties and what were the results/what were you told?

16. What treatments have been tried for this problem, and what were the results?

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