Pullman Feeding Team for Children
Case History Form

DATE OF APPOINTMENT: _____ **TIME:**_____
LOCATION: 1620 SE Summit Ct., Pullman, WA 99163

Child's Name: _____ **Age:** _____ **Birthdate:** _____

Parent/Guardian Name(s):_____
Home Phone: _____Work Phone: _____ Email: _____
Address: _____
Child's Pediatrician:_____

Birth History:

1. Did the mother have a complicated pregnancy? *If, yes, specify*_____	☐ Yes	☐ No
2. Was the mother taking any drugs or medications during pregnancy?	☐ Yes	☐ No
3. Was the pregnancy full term? *If no, baby born at* _____*weeks.*	☐ Yes	☐ No
4. Was the delivery complicated? *Breech or Caesarean*	☐ Yes	☐ No
5. Was the child considered low birth weight?	☐ Yes	☐ No
6. Were there any complications such as:	☐ Yes	☐ No
a. Cyanosis	☐ Yes	☐ No
b. Jaundice	☐ Yes	☐ No
c. Congenital Defect	☐ Yes	☐ No
d. Other: _____		
7. Was there a need for:	☐ Yes	☐ No
a. Oxygen	☐ Yes	☐ No
b. Transfusion	☐ Yes	☐ No
c. Tube Feeding	☐ Yes	☐ No

Medical History of Child:

Has your child had any of the following: Check all that apply
(*Note if Child has had immunization in space provided)*

□ Meningitis	□ Measles	□ Chicken Pox	□ Asthma
□ High Fevers	□ Mumps	□ Whooping Cough	□ Cancer
□ Neurological Disease	□ Infantile Colic	□ Diabetes	
□ Seizures	□ Heart Trouble	□ Lung/Bronchial Difficulties	

□ Otitis Media (ear infection) How many _____Treated with Antibiotics or Tubes_____
□ Physical Injury/Illness requiring Hospitalization: Specify: _____
□ Other Chronic Illness: Specify: _____
Does your child have a visual impairment? ☐ Yes ☐ No
Does your child have a hearing impairment? ☐ Yes ☐ No
Is your child on any Medications? *Please list medication, reason for taking, and dosage.*

_____
_____
_____

How is your Child Eating and Growing? *(Please circle yes or no in response to the following questions)*

1.	Is it easy to tell when your child is hungry or thirsty?	Yes	No	
2.	Do you worry about his/her eating or growing?	Yes	No	
3.	Have you received any special directions for feeding your child?	Yes	No	
4.	Does he/she take vitamins or minerals?	Yes	No	If Yes, what? _____
5.	Does he/she take herbal or other supplements?	Yes	No	If Yes, what? _____
6.	Does he/she take medications?	Yes	No	If Yes, what? _____
7.	Does your child eat anything that is not food, such as paint or dirt?	Yes	No	
8.	Do you have trouble buying or making your child's food?	Yes	No	
9.	Is your child on the WIC Program?	Yes	No	If Yes, where? _____
10.	Does your child go to daycare or school?	Yes	No	If Yes, where? _____
11.	Is your child fed by any other people?	Yes	No	If Yes, where? _____

What Does Your Child Eat and Drink?

1. At what age did you begin to introduce solids? _____
2. Where do you usually feed your child? _____
3. How many meals and snacks does he/she eat most days? _____Meals _____Snacks
4. How long does it take your child to eat? _____ Minutes
5. Please check what your child eats:

□ Breastmilk	□ Baby Cereal	□ Ground Meats/Finely Ground Table Foods
□ Formula	□ Strained Baby Foods	□ Cut Up Meats/Soft Table Foods
□ Cows Milk	□ Junior Foods	□ Finger Foods
□ Whole □ 2%	□ Skim	□ Juice

6. Circle the foods that you feel your child does not eat enough of:

Milk and milk products meat, beans, eggs fruit and vegetables breads and cereals

7. How much does your child usually drink in one day (24 hours):

Breast Milk: feedings per day _____
Baby formula_____ ounces per day. What kind of formula? (with/without iron?)
How do you mix the formula? _____
Water _____ Sweet drinks _____ Juice _____ Cow's milk _____
Sports drinks _____ Other _____

Are any of these a problem for your child? (if yes, please check)

□ vomiting	□ easily distracted when eating	□ gagging or choking
□ diarrhea	□ overstuffs mouth	□ throws food
□ excessive gas	□ sensitive around the mouth	□ eating too slowly
□ sucking on nipple	□ chewing	□ refusing foods offered
□ holding up head	□ cup drinking	□ refusing to eat any food
□ sitting up alone	□ finger feeding	□ spitting out food
□ swallowing	□ not eating solids after age one	□ getting upset at meals
□ diagnosis of reflux	□ bad teeth or sore mouth	□ picky eater
□ using a spoon	□ holding food in mouth (spillage)	□ eating has become a "battle"

Do you have any concerns about what your child eats and/or his/her eating skills?

_____

_____

Has your child ever had a swallow study? Yes ___No ____If yes, result?

_____

Has your child ever been fed other than orally (tube feeding)? Yes ___No ____Please describe:

_____

Does your child have any food restrictions/allergies (cultural/religious or other)? Yes ___ No ___

_____

Does your child breast feed? Yes ___ No ___

Does your child self-feed? Yes ___ No___

If yes, circle manner of feeding: holds own bottle uses spoon uses fork
finger feeds sippy cup regular cup

What have you tried in the past to improve feeding concerns?

_____

_____

_____

_____

Please list any questions you would like addressed or information you would like to receive from this evaluation:

_____

_____

_____

Thank you for taking the time to complete this form. It is very helpful in the care of your child.

Sincerely,

The Pullman Feeding Team for Children