Stony Brook Medicine

Pediatric Feeding & Swallowing Case History Attachment

Name: _____
Onset of difficulty: **(Date)** _____
Describe feeding/swallowing difficulty:_____
_____
Feeding History: □ Tube fed (age)_____ □ Fed by mouth (age)_____
□ Breast □ Bottle
Nipple type:_____ **Formula:**_____ **Discontinued:**_____
(date/age)
Does your child drink from a: □ Cup □Straw □ Bottle
Current diet: □ Regular table foods □ Cut up table foods □ Soft solids only
□ All puree foods □ Baby food: circle one: stage 1 2 3
□ Regular liquids □ Thickened liquid: **circle one**: nectar honey other

Easiest foods:_____
Difficult foods:_____
Favorite tastes:_____
Favorite textures:_____
Preferred temperature:_____
Please describe your child's appetite: □ Good □ Fair □ Poor
Current weight:_____ **Current height:**_____
Feeding position: □ Cradled in arms □ upright in arms □ upright in infant seat
□ upright in highchair □ upright in wheelchair □ other:_____
Length of meal: □ < 20 minutes □ 20-40 minutes □> 40 minutes
Time between feeding: □ 2 hrs. □ 3 hrs. □ 4 hrs. □ __meals per day □ other:_____
Does your child self feed? □ NO □ YES **Special utensils**? □ NO □ YES
If yes, please describe the utensils: _____
How do you give your child medication?_____

Does your child experience any of the following?

Gagging when eating:	□ NO	□ YES
Choking when eating:	□ NO	□ YES
Coughing when eating:	□ NO	□ YES
Reflux of food/vomiting:	□ NO	□ YES
Stiffening and arching back :	□ NO	□ YES
Refusal of food/liquid:	□ NO	□ YES

Food/liquid coming out of the nose when eating? □ NO □ YES

Any history of feeding/swallowing evaluation or therapy? □ NO □ YES
If yes, please provide us with the dates, name, location and phone number:_____
_____
_____