HealthCare
KENTUCKY CHILDREN'S HOSPITAL

UNIVERSITY OF KENTUCKY
SPEECH LANGUAGE PATHOLOGY

FEEDING EVALUATION HISTORY FORM

Name	Date of Birth
Primary Caregiver (s)	Address
Phone #1	
Phone #2	Email
Primary Care Physician	Additional Care Providers

Medical Diagnosis: _____

_____

Allergies:

Medications:

Hospitalizations/Surgeries:

Surgery	Date	Surgery	Date

Prenatal and Birth History

Prenatal complications: _____

How many weeks gestation when born? _____ Birth weight _____

Birthing complications: _____

Current weight: _____ Height: _____

Any difficulty maintaining appropriate weight: ☐ Yes ☐ No

Sleep

Does your child sleep through the night? ☐ Yes ☐ No

What time do they go to bed? _____ Wake up? _____

What time(s) do they nap?_____

Any difficulty sleeping? _____

Development

Please fill in the age your child started the following:

Rolling over _____ Sitting _____ Crawling _____ Walking _____

Dressing _____ Potty training _____

Sensory

Please indicate if your child has difficulty with any of the following:

Brushing teeth _____ Getting dirty _____ Playing outside _____

Swings _____ Slide _____ Haircuts _____ Loud noises _____

Other: _____

Feeding

Did your child nurse? ☐ Yes ☐ No

Did your child use a bottle? ☐ Yes ☐ No

Was nursing or bottle feeding difficult? ☐ Yes ☐ No

When did your child transition to solid foods/baby food? _____

Any difficulties transitioning to solids/baby foods? ☐ Yes ☐ No

Did/does your child use a pacifier? ☐ Yes ☐ No

Please indicate the ways your child eats and drinks:

Tube feeding: ☐ G ☐ J ☐ NG ☐ OG

Bottle (list type) _____ ☐ Sippy cup ☐ Open cup

☐ Straw ☐ Finger feeding ☐ Spoon ☐ Fork

Please indicate the foods/drinks your child eats:

☐ Liquids ☐ Purees ☐ Pudding ☐ Baby food ☐ Mashed table foods

☐ Crunchy table foods ☐ Soft table foods

What feeding difficulties does your child have? _____

_____

_____

What would you most like us to look at or work on in feeding therapy?

_____

Other Therapy Providers

Therapy Type	Facility

_____ _____

Signature of Person Completing Form Date

_____ _____

Print name Relationship to Patient

Food Diary

(Complete if your child is eating solid foods – does not need to be completed if only drinking from a bottle or tube feeding)

Meal/Snack	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**
1					
2					
3					
4					
5					
6					
7					