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* | | | | | |