TreehouseSpeech.net

**Treehouse Speech and Rehabilitation**

**Ellwood City** 26 Pittsburgh Circle, Ellwood City PA 16117 • phone 724.752.1551 • fax 724.752.8573
**Grove City** 120A South Broad Street, Grove City, PA 16127 • phone 724-458-1500 • fax 724-458-1501
**New Castle** 2656 Wilmington Road, New Castle, PA 16105 • phone 724-752-1551 • fax 724-752-8573

## Pediatric Feeding Therapy History Questionnaire

This form has important questions that help the therapists understand your child. Please fill in all areas that you can. ***Please bring any medical reports you have for our records.***

Completed by (Name/relationship to patient): _____Date:_____
**Child's Name**: _____ Date of Birth: _____ Age:_____
Address: _____
Main language used at home: _____ Other languages used:_____
Email: _____ Secondary Email: _____
Preferred Daytime Phone Number: ( ___)_____❒ Additional Phone Number:_____

**Why are you coming for an evaluation? What are your main concerns?**

_____
_____
_____

**Has your child been previously evaluated or treated by an occupational therapist, physical therapist, or speech language pathologist? Date(s) of Evaluation(s)?**

_____
_____
_____
_____

**Please indicate any known adverse/allergic drug and/or food allergies (e.g., penicillin, latex, gluten)**:

_____
_____

**Please indicate who lives at home and/or cares for your child:**

| Name | Relationship to Child (parent, sibling, nanny) | Contact Numbers | Medical Diagnoses | Occupation |
|---|---|---|---|---|
| | | Home:_____<br>Cell:_____ | | |
| | | Home:_____<br>Cell:_____ | | |
| | | Home:_____<br>Cell:_____ | | |
| | | Home:_____<br>Cell:_____ | | |

**Family Medical History**

❒ Biological Child ❒ Adoption ❒ Foster care ❒ Surrogacy
Age at adoption/foster care placement: _____
Additional Information: _____
_____
_____
_____

Pregnancy

- ❒ Complications:_____
- ❒ Medications taken during pregnancy: _____
- ❒ Prenatal exposure to ❒ alcohol ❒ tobacco ❒ drugs ❒ other: _____
- ❒ Maternal hospitalizations: because of _____
  From _____ weeks gestation to _____ weeks gestation.
- ❒ Breech Position
- ❒ Other: _____

Birth

Name of Hospital: _____ Length of Stay: _____
❒ Full Term ❒ Premature ❒ Post mature _____ Born at weeks gestation age
❒ Vaginal birth ❒ C-section Reason: _____
❒ Difficult Labor_____ ❒ Other: _____
❒ Birth Weight: _____ Apgar Scores: _____
❒ Complications: _____

Neonatal:

❒ NICU Stay Hospital: _____ Length of Stay: _____

| | |
|---|---|
| ❒ Ventilator/Breathing Tube | ❒ Difficulty Feeding |
| ❒ Oxygen Tube | ❒ Physical Therapy |
| ❒ Retinopathy of Prematurity | ❒ Occupational Therapy |
| ❒ Seizures | ❒ Speech Therapy |

❒ Intraventricular Hemorrhage (IVH) Grade ____
❒ Reflux/Gastroesophageal Reflux Disease (GERD)
❒ Periventricular Leukomalacia (PVL)
❒ Additional Diagnoses: _____
❒ Hearing Screening Results: ❒ Pass ❒ Fail
❒ Vision Screening Results: ❒ Pass ❒ Fail

Current Medical Status

Please tell us all **other doctors or specialists** involved in your child's care:

| Specialty of Physician (ENT, GI, Geneticist) | Name of Physician (First and Last) | Date Last Seen | Phone Number(s) | Fax Number |
|---|---|---|---|---|
| Pediatrician | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please list all **medical diagnoses** your child has:

| Diagnosis | Age at time of Diagnosis | Name of Physician who Diagnosed |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please list all **medications** your child takes:

| Medication | Dosage | Route (Oral, Nasal) | Frequency | Physician who Prescribed | Start Date | Stop Date |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

Does your child wear glasses or have problems seeing? _____ (Please describe)
Results of last **hearing** evaluation:_____ Date:_____
Results of last **vision** evaluation:_____ Date:_____

Please **list any additional special tests, procedures, and/or hospitalizations/surgical** since birth (MRI, EEG):

| Date | Procedure | Reason for Testing | Results of Procedure |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Development

***Please write the age when your child first performed the following skills (circle months or years)***

Sat alone: _____(Months/Years)
Crawled: _____ (Months/Years)
Walked: _____ (Months/Years)
Babbled: _____ (Months/Years)
Used a cup: _____ (Months/Years)
Toilet-trained: _____ (Months/Years)
Learned to Write: _____( Months/Years)
Said a single word: _____ (Months/Years)
Dressed Self: _____( Months/Years)
Fed self: _____ (Months/Years)

**Does your child use any of the following at home or at school?**

❒ Walker ❒ Wheelchair ❒ Special cups/spoons ❒ Pacifier ❒ Sippy cup
❒ Assistive Technology ❒ Infant "walker" or jumper ❒ Infant Swing ❒ Exersaucer
❒ Other: _____

## Speech and Language

Please list any speech/language difficulties: _____

_____

Have your child's language skills regressed? (Lost words, no longer follows directions)

_____

Does your child repeat or echo certain words or phrases? _____

_____

**Feeding**

How does your child currently receive nutrition? Check all that apply:

❒ NG-Tube
❒ Bottle: Brand (e.g., Dr. Brown, Avent) _____
Nipple type (e.g., fast, level 1): _____
❒ Open Cup
❒ Straw
❒ NJ-Tube
❒ G-Tube
❒ Sippy Cup
❒ Spoon/Fork
❒ Hands

If your child receives tube feedings, please complete the following:

❒ Continuous Feeds: _____ cc/hour for _____ hours
Beginning time: _____ Ending Time: _____

❒ Bolus Feeds: _____ cc/oz
Times Given: _____

What foods does your child currently take?

❒ Breast Milk
❒ Formula: _____
Calories (e.g., 28 kcal):_____
❒ Stage 1 Baby Food
❒ Stage 2 Baby Food
❒ Stage 3 Baby Food
❒ Pureed Table Foods
❒ Soft Chewables
❒ Pediasure
❒ Hard Chewables
❒ Chewy foods
❒ Other: _____

List your child's preferred foods/liquids: _____
List your child's non-preferred foods/liquids: _____
How long does a meal (or for infants, a bottle) usually take (e.g., 5 minutes, 1 hour)? _____

Please indicate any known adverse/allergic drug and/or food allergies (e.g., penicillin, latex, gluten):

_____
_____
_____

Does your child display any of the following behaviors related to feeding?

❒ Frequent coughing/choking related to feeding
❒ Gagging/vomiting related to feeding
❒ Refusal behaviors (e.g. head turning) related to feeding
❒ Difficulty accepting foods of certain textures
❒ Difficulty chewing
❒ Holding food in mouth
❒ Other (please describe any difficulties related to feeding/swallowing):

_____
_____

Has your child had a swallow study by a speech pathologist? ❒ Yes ❒ No
If yes: Where: _____ When: _____
Results: _____

**School or Early Intervention**
School or Service:_____City/County_____
Grade:_____ Teacher(s):_____
Support Services: _____ Approximate # of Students in Class: _____
❒ Individual Family Service Plan (IFSP) ❒ Occupational therapy
❒ Individual Education Plan (IEP) ❒ Assistive technology
❒ Adapted PE ❒ Speech therapy
❒ Physical therapy ❒ Classroom aide
❒ Other: _____
❒ Involved in organized activities or sports? _____
❒ Any concerns or difficulties?_____

**Behavior**
What are your child's favorite activities? _____
What motivates your child? _____
How does child play with brothers and sisters? ❒ Poor ❒ Fair ❒ Well ❒ N/A
How does child play with children his/her own age? ❒ Poor ❒ Fair ❒ Well
What is the length of time your child can attend to an activity? _____
Does your child have any behavior issues? _____
_____
Does your child have any attention difficulties? _____
How many hours per night does your child sleep? _____
Does your child have difficulty falling asleep? ❒ Yes ❒ No
On average, how many times does your child wake up during the night?_____
Does your child self-feed? ❒ Finger ❒ Utensils ❒ Other_____
Does your child have any repetitive behaviors? (Hand flapping, rocking, lining up toys)
_____
Is your child bothered by certain sensations / feelings?
❒ Noises ❒ Textures, clothing, or touch ❒ Movements ❒ Lights
Please Specify: _____

Please add any other additional information you would like us to know about your child:
_____
_____
_____
_____
_____
_____
_____
_____

**THIS QUESTIONNAIRE WAS REVIEWED BY:**

**Therapist's Signature: _____** **Date:** _____

## FOOD LOG (Parent/Guardian completes log for 3 days from intake until evaluation):

Day 1 DATE: _____

| Time of Day | Activity (Nap, Play time, Meal) | Length of Activity | Quality of Activity | Behaviors Noted during Activity |
|---|---|---|---|---|
| 12:00 AM | | | | |
| 1:00 AM | | | | |
| 2:00 AM | | | | |
| 3:00 AM | | | | |
| 4:00 AM | | | | |
| 5:00 AM | | | | |
| 6:00 AM | | | | |
| 7:00 AM | | | | |
| 8:00 AM | | | | |
| 9:00 AM | | | | |
| 10:00 AM | | | | |
| 11:00 AM | | | | |
| 12:30 PM | | | | |
| 1:00 PM | | | | |
| 2:00 PM | | | | |
| 3:00 PM | | | | |
| 4:00 PM | | | | |
| 5:00 PM | | | | |
| 6:00 PM | | | | |
| 7:00 PM | | | | |
| 8:00 PM | | | | |
| 9:00 PM | | | | |
| 10:00 PM | | | | |
| 11:00 PM | | | | |
| 12:00 PM | | | | |

Day 2 DATE: _____

| Time of Day | Activity (Nap, Play time, Meal) | Length of Activity | Quality of Activity | Behaviors Noted during Activity |
|---|---|---|---|---|
| 12:00 AM | | | | |
| 1:00 AM | | | | |
| 2:00 AM | | | | |
| 3:00 AM | | | | |
| 4:00 AM | | | | |
| 5:00 AM | | | | |
| 6:00 AM | | | | |
| 7:00 AM | | | | |
| 8:00 AM | | | | |
| 9:00 AM | | | | |
| 10:00 AM | | | | |
| 11:00 AM | | | | |
| 12:30 PM | | | | |
| 1:00 PM | | | | |
| 2:00 PM | | | | |
| 3:00 PM | | | | |
| 4:00 PM | | | | |
| 5:00 PM | | | | |
| 6:00 PM | | | | |
| 7:00 PM | | | | |
| 8:00 PM | | | | |
| 9:00 PM | | | | |
| 10:00 PM | | | | |
| 11:00 PM | | | | |
| 12:00 PM | | | | |

Day 3 DATE: _____

| Time of Day | Activity (Nap, Play time, Meal) | Length of Activity | Quality of Activity | Behaviors Noted during Activity |
|---|---|---|---|---|
| 12:00 AM | | | | |
| 1:00 AM | | | | |
| 2:00 AM | | | | |
| 3:00 AM | | | | |
| 4:00 AM | | | | |
| 5:00 AM | | | | |
| 6:00 AM | | | | |
| 7:00 AM | | | | |
| 8:00 AM | | | | |
| 9:00 AM | | | | |
| 10:00 AM | | | | |
| 11:00 AM | | | | |
| 12:30 PM | | | | |
| 1:00 PM | | | | |
| 2:00 PM | | | | |
| 3:00 PM | | | | |
| 4:00 PM | | | | |
| 5:00 PM | | | | |
| 6:00 PM | | | | |
| 7:00 PM | | | | |
| 8:00 PM | | | | |
| 9:00 PM | | | | |
| 10:00 PM | | | | |
| 11:00 PM | | | | |
| 12:00 PM | | | | |