Medical History and Subjective Information Form

Clinical Feeding/Videofluoroscopy

Please answer the following questions. If you need help filling out this form, we would be happy to assist you.

Patient Name_________________________________ Birth Date: _______________ Today's Date: ________________

Prenatal/Birth Histories

Pregnancy Complications:

Mother: ☐ No ☐ Yes If yes, describe

____

____

Baby: ☐ No ☐ Yes If yes, describe

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____

Labor/Delivery Complications: ☐ No ☐ Yes If yes, describe

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____

☐ Full Term ☐ Premature Gestation Age: ________________

Medical History:

Has your child been diagnosed with or experienced injuries, diseases, disorders, and/or disabilities? ☐ No ☐ Yes

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____

Has your child had any surgeries? ☐ No ☐ Yes If yes, describe (What was done and when?)

____

____

Specialists:

Is your child being followed by any Specialists?: ☐ No ☐ Yes If yes, please list details:

Specialist	**Name**	**Test and Date Seen**
☐ Audiologist/Hearing		
☐ Cardiologist		
☐ Psychologist		
☐ Psychiatrist		
☐ Gastroenterologist		
☐ Nutritionist/Dietician		
☐ Pulmonologist		
☐ Ears Nose and Throat (ENT)		
☐ Neurologist		
☐ Neurosurgeon		
☐ Ophthalmologist		
☐ Neuro-ophthalmologist		
☐ Plastic Surgeon		
☐ Chiropractor		
☐ Developmental Assessment Clinic		
☐ Speech/Language Therapist		
☐ Occupational Therapist		
☐ Physical Therapist		
☐ Other:		
☐ Other:		

What Were The Findings?:____

____

Education/Current Services:

Is your child attending school? ☐ No ☐ Yes, If yes please describe (e.g., preschool, general education, and grade, resource classroom, Special education classroom.)____

____

Is your child receiving therapy? ☐ No ☐ Yes, If yes please describe:
What: ____
Who: ____
How often: ____
Goals: ____
Where: ____

Feeding History:

What are your concerns about your child's feeding skills: (e.g., coughs when eating, difficulty transitioning to solids, picky eater, grazer): ____

____

____

Did your child have feeding difficulty with:

Liquids:

- ❖ Liquids: ☐ No ☐ Yes If yes, describe: ____

____

Solids:

- ❖ Purees: (e.g., level 1 baby food, smooth yogurt) ☐ No ☐ Yes If yes, describe: ______________________

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- ❖ Textured purees: (e.g., level 3 baby food, yogurt with fruit pieces) ☐ No ☐ Yes If yes, describe: __________

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- ❖ Dissolvable chewables: (e.g., Gerber Puffs) ☐ No ☐ Yes If yes, describe: ______________________

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- ❖ Soft chewables: (e.g., canned vegetables, banana) ☐ No ☐ Yes If yes, describe: __________________

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- ❖ Hard chewables: (e.g., meat) ☐ No ☐ Yes If yes, describe: ______________________________

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Where does your child eat (e.g., caregiver arms, chair, specialty seating)? ______________________

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How is your child fed:

☐ By mouth: Describe a typical feeding day for your child (e.g., how many meals per day and what does your child eat)

____

____

☐ Other: ☐ NG ☐ NJ ☐ OG ☐ Gastrostomy

What is the schedule: ____

Volume: ______________________ Formula (calorie count if known):______________________

What tools/utensils are used?

☐ Bottle: (brand, flow rate) ______________________	☐ Finger
☐ Cup: (regular, sippy) ______________________	☐ Spoon
☐ Straw	☐ Fork

Is there additional information that you would like us to know about your child? ☐ No ☐ Yes If yes, describe:

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