

# Pediatric Case History

## Identifying Information

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name of Parent/ Guardian completing this form: \_\_\_\_\_

## Family History

Father's/Caregiver's Name: \_\_\_\_\_

RELATIONSHIP TO CHILD (CHECK BOXES):

- Biological
- Adoptive
- Step
- Foster
- Other

Mother/Caregiver Name: \_\_\_\_\_

RELATIONSHIP TO CHILD (CHECK BOXES):

- Biological
- Adoptive
- Step
- Foster
- Other

Predominant Language Spoken in the home: \_\_\_\_\_

Client lives with: (CHECK BOXES) Both Parents/ Mother/ Father /Other:

\_\_\_\_\_

Any sibling?CHECK BOXES Y N

Is there any history of feeding, speech, language, hearing, motor, or sensory problems in other family members? CHECK BOXES Y N

If Yes, please describe. \_\_\_\_\_

### **Educational History**

School or daycare currently attending \_\_\_\_\_

Grade \_\_\_\_\_

Services your child receives at school CHECK BOXES Speech Occupational Physical

Are there any academic and/or behavioral difficulties reported? By whom? Please describe: \_\_\_\_\_

### **Birth and Medical History**

Length of pregnancy \_\_\_\_\_

Delivery CHECK BOXES

- Vaginal
- C-section
- Multiple births
- Complications during delivery

Weight at Birth \_\_\_\_\_

Current Weight \_\_\_\_\_

Please list all birth history including loss of oxygen, fetal distress, NICU stay, and any other complications during pregnancy and delivery: \_\_\_\_\_

*CHECK ALL THAT APPLY. INCLUDE AN EXPLANATION FOR ANY CHECKED BOXES. IN YOUR EXPLANATION, PLEASE INCLUDE THE CLIENT'S AGE(S) IF RELEVANT, ANY DIAGNOSES MADE, AND ANY TREATMENTS THAT HAVE OCCURRED.*

CHECK BOXES

- frequent colds or is frequently congested.

- frequent sore Throats/Strep.
- Pneumonia or Aspiration pneumonia.
- mouth breathing
- Snoring
- Obstructive sleep or central apnea
- seasonal allergies
- Sinusitis
- tracheostomy
- Bronchomalacia or laryngomalacia or tracheomalacia
- pressure equalization tubes.
- hearing loss
- tonsillectomy/ or adenoidectomy
- Lip or tongue ties released
- cardiac health concerns
- Neoplasms
- Has constipation/diarrhea problems
- Failure to gain weight
- Vomiting/digestion problems
- reflux/GERD
- Esophagitis secondary to GERD
- Dehydration
  
- frequent headaches
- seizures
- has/had a feeding tube (NG, J, G, Gavage)

If there are any Yes responses above, please elaborate below:

\_\_\_\_\_

List any conditions, disorders, or diseases of the Nervous/Circulatory/  
Respiratory/Musculoskeletal systems: \_\_\_\_\_

List any congenital malformations, deformities, or chromosomal abnormalities.

\_\_\_\_\_

Allergies/ Intolerances \_\_\_\_\_

Medications (include name, dosage, reason & any negative reactions).

\_\_\_\_\_

Hospitalizations and surgeries? \_\_\_\_\_

Instrumental evaluations of swallowing function? Check any that apply.

- Modified Barium Swallow study (MBSS)
- Videofluoroscopic Swallow study (VFSS)
- Fiberoptic Endoscopic Evaluation of Swallowing (FEES)
- Upper GI
- pH probe

Please upload or bring a copy of any reports to your child's evaluation.

UPLOAD BOX

## **Behavioral History**

Check all that apply CHECK BOXES

- Nervous
- Hyperactive
- Difficulty concentrating, short attention span
- Sleepless
- Wets bed
- Nightmares/ Night Terrors
- Sad
- Shy
- Easily upset
- Destructive
- Aggressive
- Head-banging
- Rocking, flapping, other self-stimulatory behaviors
- Anxious
- Sensitive to sounds and/or lights

- Doesn't notice loud noises
- Doesn't like being touched
- perseverative behaviors (does something over and over)

### **Breast and Bottle Feeding History**

Was the client breast fed? **Y N** From age to age? \_\_\_\_\_

- Did you experience pain while breastfeeding your child? **Y N**

Was the client bottle fed? **Y N** From age to age? \_\_\_\_\_

During feedings did your child ever: CHECK BOXES

- Frequently arch their back
- Cry, scream
- Spit up
- Gag or Cough
- Pull at nipple
- Show signs of distress (shudder, grimace, turn away, splay fingers, etc)
- Seem out of breath or noisy breathing

My child: CHECK BOXES

- latched immediately following birth
- had trouble latching at birth, but eventually figured it out
- had trouble latching at birth and breastfeeding was unsuccessful
- has/had a shallow latch
- uses/used a nipple shield to successfully breastfeed
- uses/used supplemental nursing system (SNS)
- uses/used a finger feeder
- uses/used a syringe for feeding

Bottle Feeding:

Please list any and all bottles, nipples, and/or feeding systems attempted to date:

\_\_\_\_\_

Please add any additional information that you feel is important to share regarding breast or bottle feeding (e.g., if you worked with an IBCLC or other feeding therapist, if you needed to triple feed your baby, etc.): \_\_\_\_\_

## **Feeding History**

Please list the age that your child reached the following feeding milestones:

- Ate cut up table foods/ finger foods (ex: peas, rice, diced peaches): \_\_\_\_\_
- Drank from a straw cup: \_\_\_\_\_
- Drank from an open cup: \_\_\_\_\_
- Used a spoon and fork independently: \_\_\_\_\_
- Weaned from pacifier: \_\_\_\_\_
- Weaned from sippy cup: \_\_\_\_\_
- When teeth erupted: \_\_\_\_\_

Please check the following as they apply to your child: CHECK BOXES

- Thumb or finger sucking
- Nail biting
- object mouthing/chewing
- Clenching/grinding teeth
- Extended pacifier or sippy cup use (past 12 months of age)
- Excessive drooling
- Food or liquid from nose
- Strong food preferences (e.g. certain tastes, textures, shapes, color, or brands)
- Low volume of food
- Poor appetite
- Had trouble transitioning between stages of food
- Is a "picky" eater
- Turn head/closes mouth when food approaches
- My child's a noisy eater (e.g., chomps when eating)
- My child's a messy eater (e.g., food falls out of mouth)
- Eats no fruits

- Eats no vegetables
- Has difficulty chewing; may pocket food or hold onto it for long periods of time.
- My child takes large bites
- My child takes small bites
- My child needs to swallow liquid to completely clear mouth while eating
- Coughs or chokes on food frequently
- My child sounds gurgly after eating
- Hiccups after eating
- Burps during or following a meal/snack
- My child complains about stomach aches
- My child eats less than 10 foods
- My child eats less than 20 foods.
- My child has difficulty brushing teeth

List the foods the client will currently eat and drink:

\_\_\_\_\_

Favorite Foods?

\_\_\_\_\_

List any foods the client refuses.

\_\_\_\_\_

Indicate with a check mark any aversions/problems or preferences your child may have. Included are examples of each food group. CHECK BOXES

	Likes	Dislikes	Refuses	Difficulty Managing
Thin liquids (i.e. water)				
Thick liquids (i.e. milkshake)				

Smooth Purees (i.e. pudding)				
Textured Purees (i.e. applesauce)				
Mixed textures (ie. soup)				
Soft Solids (i.e. banana, cheese)				
Crunchy (i.e. chips, crackers)				
Chewy (i.e. meat)				
Hard crunchy (i.e. raw carrot)				
Cold foods				
Room temperature foods				
Warm/hot foods				

**Mealtime Behaviors:**

Who does your child eat with? \_\_\_\_\_

Where does your child eat (i.e. at table, roaming, in front of tv/tablet, etc) ?

\_\_\_\_\_

In what position is your child most comfortable eating? Check all that apply. CHECK BOXES

- Highchair
- Chair at table
- Standing
- Lap
- Laying Down

Does your child self-feed? Y N If yes, how? CHECK BOXES

- Fingers

- spoon
- fork
- straw
- open cup

Does your child use any special equipment to eat? \_\_\_\_\_

What behaviors does your child demonstrate during mealtime? Please check all that apply:

- Throws food
- Spits food out
- Leaves or tries to leave table before done
- Trouble with self-feeding
- Refusal to eat
- Takes food from other's plate
- Has to be distracted

On average, how long does each meal take? \_\_\_\_\_

How many times per day does your child eat? \_\_\_\_\_

How long is it between meals? \_\_\_\_\_

How do you know if your child is hungry? \_\_\_\_\_

How do you know when your child is full? \_\_\_\_\_

Anything else you feel we should know? \_\_\_\_\_