PATIENT LABEL AREA

PHYSICAL THERAPY AT StLuke's

# PATIENT MEDICAL HISTORY
# PEDIATRIC REHAB FEEDING CASE HISTORY

Patient Name: _____ Date: _____

What services are you seeking? ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Feeding Therapy

Date of Birth: _____ Sex: ☐ Male ☐ Female

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Please mark which phone is your primary contact number.*** Person completing this form: _____

Primary Care Physician: _____ Specialist Physicians: _____

_____

Current educational setting/support/services: Please list: _____

_____

Medical History: Please list current medical diagnoses and date of diagnosis: _____

_____

Birth History: Length of pregnancy: _____ Duration of Labor: _____ Delivered via: ☐ Cesarean ☐ Vaginal

Birth weight: _____ Birth Length: _____ Please list any complications: _____

Did the child require any of the following: NICU: ☐ Yes ☐ No Special Care Nursery: ☐ Yes ☐ No

Oxygen: ☐ Yes ☐ No Incubator: ☐ Yes ☐ No Other: _____

Please list age at which the child was able to do the following: Held Head up: _____ Sat without support: _____

Rolled Over: _____ Crawled: _____ Stood alone: _____ Walked independently _____ Toilet Trained: _____

Any current or past difficulties with sucking, chewing or swallowing? _____

Please list other medical history/surgical history/hospitalizations: _____

_____

Has your child had hearing screened? ☐ Yes ☐ No If yes, what were results? _____

Has your child had vision screened? ☐ Yes ☐ No If yes, what were results? _____

Please list all medications your child is presently taking. _____

_____

Any allergies? ☐ Yes ☐ No If yes, please list: _____

Names of other children in the family: Please list names, ages: _____

Names of adults living in the home: Please list relationship: _____

Has anyone in your family needed special education services, therapies, speech services? _____

_____

Have you had any of the following this year? ☐ Physical therapy ☐ Occupational therapy ☐ Speech therapy ☐ Early Intervention Home Care ☐ Feeding Therapy If yes, where were you treated, when were you treated and for what condition? _____

_____

We will do our best to work with you and your child's schedule; however, we ask for your flexibility to find a consistent time for therapy.

Please list your availability for therapy sessions: _____

_____

**Patient's Signature:** _____

*Please turn page over* ⟶

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**Feeding History:**

Was your child breast fed: ☐ Yes ☐ No

If yes, how long? _____ Were there any problems with this (e.g.: poor suck, slow to feed)? _____

When was your child first given a bottle? _____ Were there any problems with this? _____

When did your child start to eat solid foods? _____ Were there any problems with this? _____

When was your child weaned from the breast? _____

When did your child start to feed him or herself? _____

Does your child drink juice? ☐ Yes ☐ No If yes, how much? _____

Does your child exhibit any of the following behaviors during feeding:

_____crying _____spitting food from his/her mouth _____holding food in his/her mouth

_____gagging _____regurgitating food _____getting down from the table

_____vomiting

How many times a day does your child eat? _____

If your child does not feed him/herself, who feeds him/her? _____

Where does your child eat? _____

How is your child positioned when eating( high chair, sitting on the floor)? _____

Who else is present for meals? _____

Does your child eat more/less, same/different foods when he/she is at daycare, babysitter, grandparents or other? _____

_____

Does you child receive supplemental tube feedings? _____

If yes, amount: _____ NG: _____

rate: _____ PEG: _____

PEJ: _____

Bolus: (given via syringe several times a day): _____ Continuous(connected to a pump): _____

What consistency of foods does your child eat?

Regular liquids: _____

Thickened liquids: _____

Baby cereal: _____

Stage 1 baby food: _____

Stage 2 baby cereal (semi chunky): _____

Stage 3 baby food (chunky): _____

Mashed table foods: _____

Regular table food: _____

How is liquid presented?

_____bottle: _____

_____type of bottle: _____

_____breast: _____

_____cup

_____spout

_____lid with no spout

_____cut out cup

Approximately how much liquid does your child drink at each meal? _____

Approximately how much food does your child eat at each meal? _____

What do you do when your child does not eat properly? _____

What are some of your childs favorite foods? _____

If different from favorite foods, what foods are easy for you child to eat? _____

What foods will your child not eat? _____

If different, what foods are not difficult to eat? _____

List some good things that your child does at meal times? _____

List some things that that your child should be doing at mealtimes that he/she does not do? _____

List some things you think your child should not be doing at meal times: _____

What have you done to try to help your child with his/her feeding problems? _____

Please describe any other feeding problems your child is experiencing: _____

_____

Has your child had a previous swallow study? _____ Results: _____

*Please turn page over* ⟶

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# PEDIATRIC REHAB FEEDING CASE HISTORY

Food Log – For the next three days, please indicate the type of food and amount consumed by your child:

| DAY ONE | DAY TWO | DAY THREE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Medical History:**

Current Diagnosis: _____

History of Disease (colds, ear infections, bronchitis, high fevers,etc.) or surgery

Date: Severity: Temperature:

_____

_____

_____

_____

Describe any hospitalizations: _____

_____

Has your child had the following conditions:

Motor Difficulties: _____ Physical Weakness: _____

Temper Tantrums: _____ Seizures: _____

Head Banging: _____ Ear Infections: _____

Staring Spells: _____ Drooling: _____

**Required to be Completed:**

**What is your primary language?** _____

**What is your preferred language?** _____

## FOR AUTHORIZED USE ONLY

To Be Completed By the Therapist:

Does the patient show signs of or indicate to you that they are currently experiencing any of the following:

| | | |
|---|---|---|
| Abuse: | ☐ Yes | ☐ No |
| Neglect: | ☐ Yes | ☐ No |
| Depression: | ☐ Yes | ☐ No |
| Suicidal Thoughts: | ☐ Yes | ☐ No |

Therapist's Signature: _____

Print Name: _____

Date: _____ Time: _____