PHYSICAL THERAPY AT St Luke's Pediatric Therapy

PATIENT MEDICAL HISTORY
PEDIATRIC FEEDING THERAPY CASE HISTORY

*Patient Name:_____ Today's Date:_____

*Date of Birth:_____ Soc. Security #:_____ *Gender: Male Female

Ethnicity:_____ Religion: _____ Primary Language:_____

*Home Address: _____

***Primary Phone #**: _____

*Parent 1 Name:_____ DOB:_____

Parent 1 Address if different from patient:_____

Parent 1 Primary Phone #:_____ Other Phone #:_____

Parent 1 Employer:_____ Occupation:_____

*Parent 2 Name: _____ DOB:_____

Parent 2 Address if different from patient:_____

Parent 2 Primary Phone #: _____ Other Phone #:_____

Parent 2 Employer:_____ Occupation:_____

Siblings Names & Ages:_____

_____

***Person completing this form:**_____ ***Relationship to Patient:**_____

*Primary Care Physician (PCP):_____ PCP Phone:_____

*Referring Physician:_____ Ref. Physician Phone:_____

Specialist Physician: _____ Spec. Physician Phone:_____

Are you transferring from another Facility? Yes / No If yes, Please name facility:_____

*Patient Preferred Language:_____

Parent 1 Primary Language:_____ Preferred language:_____

Parent 2 Primary Language:_____ Preferred language:_____

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Professional Evaluations					
Has your child been evaluated by any of the following? (Please check all that apply and provide copies of reports)					
	Evaluations		**Provider Name**	**Evaluation Date**	**Diagnosis**
Developmental Pediatrician	Yes	No			
Gastroenterologist	Yes	No			
Dietitian	Yes	No			
Lactation Consultant	Yes	No			
Physical Therapist	Yes	No			
Occupational Therapist	Yes	No			
Speech Therapist	Yes	No			
Other:	Yes	No			

Hospitalizations and/or Surgeries		
Date	**Reason**	**Location**

Diagnostic Tests			
Chest/Abdominal X- Ray	Yes	No	Results:
Colonoscopy	Yes	No	Results:
Endoscopy	Yes	No	Results:
Ultra Sound	Yes	No	Results:
Swallowing Study	Yes	No	Results:
Upper GI	Yes	No	Results:
Has your child had a vision evaluation	Yes**	No	** If yes, what were the results
Has your child had a hearing evaluation?	Yes**	No	** If yes, what were the results

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Past Medical History (please circle)					
Asthma	Yes	No	Infection (Menigitis, Encephalitis)	Yes	No
Bronchiolitis/Bronchitis	Yes	No	Intubation	Yes	No
BPD (bronchopulmonary dysplasia)	Yes	No	Limited volume/quantity of intake	Yes	No
Cancer/tumor	Yes	No	PIKA (eating non-edible items)	Yes	No
Cleft lip/palate	Yes	No	Pneumonia	Yes	No
Constipation	Yes	No	Pocketing Foods, (Chipmunk, Holds Food In Cheeks)	Yes	No
Coughing/choking	Yes	No	Poor secretion management	Yes	No
Cyanotic episode (turned blue/stopped breathing)	Yes	No	Seizures	Yes	No
Dehydration	Yes	No	Skin Rash	Yes	No
Difficulty swallowing	Yes	No	Stridor/Noisy breathing	Yes	No
Difficulty chewing	Yes	No	Texture/flavor refusal	Yes	No
Diarrhea	Yes	No	Tooth decay	Yes	No
Ear Infections	Yes	No	Tooth extraction/dental surgery	Yes	No
Eczema	Yes	No	Tracheoesophageal Fistula	Yes	No
Eosinophilic Esophagitis (EoE)	Yes	No	Tracheostomy	Yes	No
Failure to thrive (FTT)	Yes	No	Tonsillitis	Yes	No
Floppy airway (laryngomalacia)	Yes	No	Upper respiratory Infection	Yes	No
Food allergy	Yes	No	Vomiting	Yes	No
Food refusal	Yes	No	Weight loss/Slow weight gain	Yes	No
Fundoplication	Yes	No	Wet vocal quality	Yes	No
GERD/Reflux	Yes	No	Torticollis	Yes	No
Gastroparesis	Yes	No	Tongue tie	Yes	No
Heart Problems	Yes	No	Other:	Yes	No
Head Injury	Yes	No	Other:	Yes	No

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Feeding background						
What are your feeding concerns for your child?						
What are your feeding therapy goals for your family?						
When did the feeding problems begin?						
Current weight:		Current length:		Head Circumference:		

Child's typical weekly routine			
Attends:	Daycare	Preschool	School
Facility Name:		Grade/Classroom Type:	
Days and Times:	Monday_____ Tuesday_____ Wednesday_____ Thursday_____ Friday _____		
Support Services (Include days and times):			
Extracurricular Activities (Include days and times):			

Birth History:						
First Child?	Yes	No	Birth Order:			
Single or Multiple Birth?	Single	Multiple **	** If Multiple Birth: Twin A or Twin B			
Born Prematurely?	Yes**	No	Length of pregnancy:			
***Did your child require any of the following:	NICU	NICU length of stay:		Incubator	Special Care Nursery	Oxygen
Birth weight			Birth length			
Complications during pregnancy?	Yes**	No	** If Yes, Please List:			
Complications during Delivery?	Yes**	No	** If Yes, Please List:			
Mother's age at birth?			Child's Utero Position			
Delivery:	Vaginal	C-Section	Vacuum	Nuchal Cord	Other:	
Other Medications taken during pregnancy	Yes**	No	** If Yes, Please list:			
Medications taken during delivery	Yes**	No	** If Yes, Please list:			
Results of Newborn Hearing Screening	Pass	Fail**	** If fail, what were results?			
Did the infant receive therapy services prior to	Yes**	No	**If Yes, Please describe:			

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Early Milestones Developmental (list the age in months)			
Mouthing of toys/hands:		Sat without support:	
Held head up:		Started crawling:	
Rolled over:		Started walking:	
Started babbling:		Walking independently:	
Toilet trained:		First words:	

Previous Services					
Has your child received any of the following this year? (Please check all that apply)					
Speech Therapy	Yes	No	**Early Intervention**	Yes	No
Occupational Therapy	Yes	No	**WIC Services**	Yes	No
Inpatient Feeding Therapy	Yes	No	**Outpatient Feeding Therapy**	Yes	No
Physical Therapy	Yes	No	**Counseling**	Yes	No

Early Feeding History					
			Duration		List difficulties
Breast Fed	Yes	No			
Bottle Fed	Yes	No			
Formulas trialed:			Current Formula		
Why was formula changed?					
Tube Fed	Yes	No			
			Date of placement		Date of removal
NG Tube	Yes	No			
OG Tube	Yes	No			
GJ Tube	Yes	No			
G/PEG Tube	Yes	No			
NJ Tube	Yes	No			
Feeding schedule	Continuous	Bolus	Number of times per day	Length of feed time	Total volume per day
If not fed by mouth, why were oral feeds discontinued?					

Solid Feeding History				
Age pureed foods were introduced:	Difficulties Noted? **if yes please explain	Yes	No	
Did your child transition to lumpy/thick foods?	Yes	No		
Age solid table foods were introduced:	Difficulties Noted? **if yes, please explain:	Yes	No	

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Current Feeding Routine			
How often does your child eat meals (per day)?	0	1-2	3
How often does your child eat snacks (per day)?	Grazes through the day	1-2	2-3
Length of meals	5-10 minutes	15-25 minutes	>30 minutes
How would you describe your child's appetite?	Poor-Fair	Good	Excellent
Does your child let you now when they are hungry?	Yes	No	

What food(s) and drink(s) does your child prefer for each meal?			
Breakfast	**Lunch**	**Dinner**	**Snack(s)**

Current food textures (please circle)			
Regular/thin liquid	Child eats	Child does not eat	Food type not offered
Thickened liquid	Child eats	Child does not eat	Food type not offered
Commercially pureed baby foods (stage I and II)	Child eats	Child does not eat	Food type not offered
Ground or commercial third stage foods	Child eats	Child does not eat	Food type not offered
Mashed soft table foods	Child eats	Child does not eat	Food type not offered
Regular table foods (easy-meltable/soft foods)	Child eats	Child does not eat	Food type not offered
Regular table foods (dense/hard foods)	Child eats	Child does not eat	Food type not offered
Other:	Child eats	Child does not eat	Food type not offered

Which of these foods are easiest for your child? Please list specific examples	Which of these foods are hardest for your child? Please list specific examples.

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Does your child exhibit any of the following when drinking or eating?					
	Drinking	**Eating**		**Drinking**	**Eating**
Choking	Yes	No	**Crying**	Yes	No
Gagging	Yes	No	**Refusal**	Yes	No
Vomiting	Yes	No	**Tantrums**	Yes	No
Color Changes	Yes	No	**Throwing food**	Yes	No
Breath holding	Yes	No	**Expelling food from mouth**	Yes	No
Wet Vocal quality	Yes	No	**Holding food in mouth**	Yes	No

Environmental status							
Where do meals take place (Circle all that apply)	Highchair	Booster seat	Pediatric chair	Adult size chair	Caregiver's lap	Child wanders for meals	Other:

Where do meals take place? (check all that apply)			
	Intake in this environment:		
Home	More	Less	Same
School	More	Less	Same
Daycare	More	Less	Same
Family Members Home	More	Less	Same
Other:	More	Less	Same

Who typically feeds your child? (check all that apply)			
	Intake for this caregiver:		
Parent	More	Less	Same
Grandparent	More	Less	Same
Other family member	More	Less	Same
Daycare staff	More	Less	Same
Nursing staff	More	Less	Same
Other:	More	Less	Same

Does your child use the following independently?					
Fork	Yes	No	**Spoon**	Yes	No
Fingers	Yes	No	**Straw**	Yes	No
Open cup	Yes	No	**Bottle**	Yes	No
Sippy Cup	Yes	No			

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Food Log: For the next three days, please indicate the time, type of food and amount consumed by your child.		
Day 1		
Time:	Food Presented/Approximate Amount Accepted	Observation/Comment
Day 2		
Time:	Food Presented/Approximate Amount Accepted	Observation/Comment
Day 3		
Time:	Food Presented/Approximate Amount Accepted	Observation/Comment

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Vaccination History and Dates received:			
Hepatitis B (HepB)		**Varicella (VAR)**	
Rotavirus (RV)		**Hepatitis A (HepA)**	
Diptheria, Tetanus, & Acelluar perussis (DtaP <7 yrs)		**Diptheria, Tetanus & Acelluar perussis (Dtap >7 yrs)**	
Pneumococcal conjugate (PCV13)		**Human Papillomavirus (HPV)**	
Inactivate poliorirus (IPV)		**Meningococcal B (MenB)**	
Measles, mumps,rubella (MMR)		**Influenza**	

Medication List				
Start Date	**Drug**	**Dose**	**Frequency/Route**	**Stop Date**

*Allergies: Please list all:_____

_____

*Patient's Signature:_____ Date:_____

*Legal Guardian Signature: _____

*Print Guardian's Name:_____ Therapist initials:_____