Feeding History

Infant/Child's Name: _____

DOB: ____/____/_____ Age: _____ Gender: M / F Gestational age: ____/40

Mother's Name: _____ Mobile: _____

Father's Name: _____ Mobile: _____

Guardians Name (Other): _____ Mobile: _____

Address: _____

Suburb: _____ Postcode: _____

Email: _____

Child lives with: ☐ Both Parents ☐ Mother ☐ Father

☐ Shared Custody _____ ☐ Guardian/Other

Medical History: (eg. Illness, reflux, surgery)

_____

_____

Medications: (prescribed & over the counter)

_____ Date Started: _____ Date Ceased:_____

_____ Date Started: _____ Date Ceased:_____

_____ Date Started: _____ Date Ceased:_____

How do you give your child medication? _____

Onset of feeding difficulty: Age: _____ (Date) _____

Describe feeding/swallowing/difficulty: _____

_____

_____

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Feeding History:

☐ Tube fed Age commenced: _____ Age Ceased: _____

☐ Fed by mouth Age Commenced: _____

☐ Breast/ EBM Currently Breastfed ☐ YES ☐ NO Age Ceased: _____

☐ Formula Formula Type: _____

☐ Thickener _____ Teat Type: _____

Age ceased: _____

Does your child drink from a: ☐ Cup ☐ Straw ☐ Bottle ☐ Other: _____

Current diet: ☐ Regular table foods ☐ Cut up table foods ☐ Soft solids only

☐ All puree foods ☐ Commercial baby food (Jar/pouches)

Thickness of liquids: ☐ Regular liquids ☐ Infant thick ☐ Mildly thick

☐ Moderately Thick ☐ Extremely thick ☐ Other: _____

Easiest foods: _____

Difficult foods: _____

Favourite foods: _____

Favourite textures: _____

Preferred temperature: _____

Please describe your child's appetite: ☐ Good ☐ Fair ☐ Poor

Current weight: _____ kg Current length/height: _____cm

Feeding position: ☐ Cradled in arms ☐ Upright in arms ☐ Upright in infant seat

☐ Upright in highchair ☐ Upright in wheelchair ☐ Other: _____

Length of meal: ☐ <20minutes ☐ 20-40minutes ☐ >40 minutes

Time between feeding: ☐ 2 hours ☐ 3 hours ☐ 4 hours

☐ _____ meals per day ☐ Other: _____

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Does your child self feed? ☐ NO ☐ YES Special Utensils? ☐ NO ☐ YES

If YES, please describe the utensils: _____

_____

Does your child experience any of the following:

Gagging when eating:	☐ NO	☐ YES
Choking when eating:	☐ NO	☐ YES
Coughing when eating:	☐ NO	☐ YES
Reflux of food/vomiting:	☐ NO	☐ YES
Stiffening and arching back:	☐ NO	☐ YES
Refusal of food/liquid:	☐ NO	☐ YES
Food/liquid coming out of nose when eating?	☐ NO	☐ YES
Does your child suffer from constipation?	☐ NO	☐ YES
Does your child suffer from diarrhoea?	☐ NO	☐ YES

Any history of feeding/swallowing evaluation or therapy? ☐ NO ☐ YES

If YES, please provide us with the dates, name, location and phone number:

_____

_____

_____

Any additional information relevant to this assessment? (eg. Family history of Crohn's, IBS, diverticulitis, traumatic life events, mental health illness)

_____

_____

Thank you for completing this Feeding History Form. Please email to nurse@babystepshealth.com.au and you will be contacted within 3 business days for an appointment with our Child Health Nurse and GP.

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