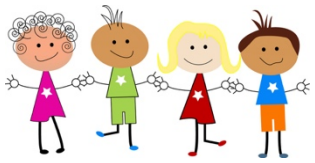
ABOUT MY CHILD • FEEDING THERAPY

Today's Date: ____/____/____

Child's Name: _____

Date of Birth: ____/____/____



Height: ____' ____" **Weight:** _____ **lbs**

How did you hear about us? _____

Emergency contact: _____ Phone: (____) ____-____
Relationship: _____

What is the main reason you are seeking help for your child? _____

_____

MEDICAL STATUS

Food or medical allergies: _____

_____

Illnesses currently being treated: _____

_____

Medications presently taken: _____

_____

BACKGROUND

What are your primary concerns regarding your child's eating/drinking abilities? _____

_____

_____

Has your child ever had a feeding evaluation/screening? Yes No
If yes, where and when? _____

Has your child received feeding therapy in the past? Yes No
If yes, where and when? _____

Has your child received any other evaluation or therapy (counseling, physical therapy, occupational therapy)?

Yes No

If yes, describe: _____

What do you see as your child's most difficult challenge at home? _____

_____

Does your child…

Choke on food or liquids?	Yes	No
Put toys/objects in their mouth?	Yes	No
Brush their teeth and/or allow brushing?	Yes	No

BIRTH

Was there anything unusual about the pregnancy or birth? Yes No

If yes, describe: _____

_____

Has your child ever experienced any of the following?

Adenoidectomy	Yes	No	
Sleeping difficulties	Yes	No	
Tonsillectomy	Yes	No	
Ear tubes	Yes	No	If yes, when: _____
Encephalitis	Yes	No	
Sinusitis	Yes	No	
Frequent colds	Yes	No	
Ear infections	Yes	No	If yes, how often? _____
Seizures	Yes	No	
Thumb/finger sucking	Yes	No	
Allergies	Yes	No	
Head injury	Yes	No	
Vision problems	Yes	No	

Other serious injuries/surgeries: _____

_____