Curative Care
New Berlin Therapies
Dedicated to Helping People Thrive

Pediatric Feeding History Form

Patient Name:_____

Primary Feeding Concerns: _____

When did feeding concerns begin? _____

Feeding History:

Breastfed: □ No □ Yes – If so, how long? _____

List age foods started: Strained Baby Foods_____ Solids/Table Foods_____ Cup Use_____

Does your child have a history of reflux or spitting up during or after meals? □ No □ Yes (if Yes, list medication for reflux if applicable): _____

Current Feeding Information:

Child eats: □ Spoon-fed □ Tube-fed □ Fingers □ Fork/Spoon (self) □ Adaptive equipment

Child drinks from a: □ Bottle □ Sippy Cup □ Straw □ Open Cup

Does your child have a good appetite? □ Yes □ No (if no, please explain):_____
_____

Is your child a picky eater? □ No □ Yes (if yes, please explain): _____
_____

Does your child refuse/sensitive to any food tastes, textures or temperatures? □ No □ Yes (if yes, explain):_____

Describe typical foods/liquids consumed at:

Breakfast: _____

Lunch: _____

Dinner: _____

Does your child cough or choke frequently? □ No □ Yes (if yes, please explain): _____
_____

Other Information:

Does your child drool? □ No □ Yes (if yes, please explain): _____

Does your child suck his thumb? □ No □ Yes (if yes, how often): _____

Does your child use a pacifier? □ No □ Yes (if yes, how often): _____

Does your child suffer from constipation or diarrhea? □ No □ Yes (explain): _____
_____

Please list any other information you would like the therapist to know about your child's feeding and nutrition: _____
_____

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist Signature Date