



Sensory Solutions, LLC

Physical, Speech and Occupational Therapy for Children

Feeding Team History Form

***Please fill out the questionnaire as accurately and completely as possible.**

Child's Name: _____ Birth Date: _____

Person Completing this Form and relationship: _____

Referred by: _____

Diagnosis(es) (i.e., Autism, Down syndrome, ADHD, etc.) _____

What are your concerns regarding your child? _____

Parent/Guardian Name: _____

Relationship to Child: Biological Foster Adoptive Other: _____

Address: _____

Zip Code: _____ Cell Phone: _____ Home Phone: _____

Email: _____

Education: _____ Occupation: _____

Employer: _____ Work Phone: _____

Parent/Guardian Name: _____

Relationship to Child: Biological Foster Adoptive Other: _____

Address _____

Zip Code: _____ Cell Phone: _____ Home Phone: _____

Email: _____

Education: _____ Occupation: _____

Employer: _____ Work Phone: _____

Marital Status (Please check): Married Separated Divorced Widowed Single
 Domestic Partnership

Emergency contact information:

Name: _____ Relationship: _____

Phone Number: _____

Child's Pediatrician: _____

How long has your child been under this physician's care?: _____

Is any language other than English used in the home: Yes No

If yes, what language(s): _____



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MEDICAL HISTORY:

Pregnancy: ___ Full Term ___ Premature

Length of Pregnancy: _____(weeks or months)

Problems encountered during pregnancy (e.g., illnesses, injuries, stress, bleeding, fainting spells, anemia, etc.): _____

Length of total labor: _____

Labor/Delivery Complications:

___ Induced Birth

___ Breech Presentation

___ Limpness

___ Stiffness

___ Other: _____

Elaborate on above labor/delivery complications: _____

Delivery Type:

___ Vaginal

___ C-section

Complications following birth regarding child:

___ Jaundice

___ Cyanosis

___ Congenital defects

___ Other (please specify): _____

Length of hospitalization: _____ Child's birth weight: _____ lbs. _____ oz

Did your baby require any of the following:

___ Oxygen How long: _____

___ Transfusions Type(s): _____

___ Tube Feedings Type(s) and how long: _____

Other (please specify): _____

Were there any feeding difficulties at birth: ___ Yes ___ No

Creve Coeur Location

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South County Location

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Please specify feeding difficulties at birth: _____

List illnesses/diseases/injuries/operations your child has experienced:

Illness: _____ Age: _____

Illness: _____ Age: _____

Illness: _____ Age: _____

Injury/operation: _____ Age: _____

Injury/operation: _____ Age: _____

Injury/operation: _____ Age: _____

Has your child experienced convulsions/seizures: Yes No

Age: _____ Type: _____ Frequency: _____ Medication: _____

Has your child experienced ear infections: Yes No Frequency: _____

Has your child had tubes placed: Yes No When: _____

Date of last hearing evaluation: _____ Results: _____

Where was the hearing evaluation completed: _____

Date of last vision evaluation: _____ Results: _____

Where was the vision evaluation completed: _____

Allergies:

None

Seasonal

Food

Other

Please list all allergies: _____

History of acid reflux: Yes No

If yes, when and how was it treated: _____

Is your child currently taking any medications/vitamins/supplements: Yes No

If yes, type(s): _____

SPECIALTY SERVICES YOUR CHILD RECEIVES:

Audiologist

Behavior Therapist

Cardiologist

Chiropractor

Dietitian

ENT

Neurologist

Occupational Therapist

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Ophthalmologist Optometrist Orthopedist Physical Therapist
 Psychologist Psychiatrist Speech Pathologist GI
 Other (please specify): _____

DEVELOPMENTAL HISTORY:

Developmental Milestones:

Approximate ages in which your child completed the following routinely:

Held up head (while on stomach): _____

Rolled over: _____

Sat independently: _____

Belly crawled: _____

Crawled on hands and knees: _____

Pulled to standing: _____

Standing independently: _____

Walking independently: _____

Babbling: _____ Were there a variety of sounds: _____

Producing single words: _____

Combining two words: _____

Obeying simple commands: _____

FEEDING:

History of Feeding Method	Age Introduced/Duration	Difficulties Noted
Feeding tube		
Breast-fed		
Bottle-fed		
Stage 1 baby food		
Stage 2 baby food		
Stage 3 baby food		
Table foods		
Cup with Spout		
Soft straw drinking		
Hard straw drinking		
Open cup drinking		
Spoon		
Fork		
Knife		

Comments on above: _____



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TUBE FEEDINGS:

Type of tube currently using: _____

Feedings per day: _____ Length of Feedings: _____

Volume per Feeding: _____

Comments on above: _____

BREAST/BOTTLE FEEDING:

Bottle nipple brand and level: _____

Nipple shield required during breastfeeding? _____ Yes _____ No

Has your child been diagnosed with a tongue or lip tie? _____ Yes _____ No

*If yes, at what age and who provided the diagnosis? _____

If your child was diagnosed with a tongue or lip tie, was a release completed?

_____ Yes _____ No

*If yes, who performed the release? _____

Position during feeding: _____

CURRENT BABY FOOD/TABLE FOOD FEEDING:

History of Sensory Preferences	Preferred	Non-preferred
Sweet		
Sour		
Bitter		
Bland		
Salty		
Spicy		
Smooth purees		
Chunky purees		
Soft Solids		
Hard Solids		
Hot Foods		
Warm foods		
Room Temperature Foods		
Cold Foods		

Comments on above: _____

Feeds self: __All __Most __Some __Rare

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Food Category	Current Foods Consumed
Protein	
Dairy	
Vegetables	
Fruits	
Grains	
Other	

Comments on above: _____

List avoided foods: _____

CURRENT RESPONSE TO FEEDING:

Behavior	Always/Often/ Sometimes/Never	Additional Comments
Acid Reflux		
Arching Back		
Choking		
Coughing		
Crying		
Difficulty Chewing		
Drooling		
Eating Too Fast		
Eating Too Slow		
Fails To Chew Food		



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Frequently Changes Nipple		
Gagging		
Getting Down from Table		
Hiccupping		
Holding Food in Mouth		
Nasal Regurgitation		
Pockets Food		
Poor Intake		
Refuses to Open Mouth		
Refuses to Eat		
Spillage of Food/Liquid		
Spits Out Food		
Stuffs Mouth		
Throws Food		
Turns Head Away		
Vomiting		

NUTRITION:

Usual Food, Beverage, and Feeding Schedule: *Please record the time, food/formula/ beverages/human milk/tube feedings consumed, amount/volume, duration of ingestion time, and location feedings take place. Please include any nutritional supplements, vitamins, and other supplements. The first entry is an example of how to complete. Please continue onto next page.*

Time	Solids/Liquids	Amount	Duration	Location
9 AM	Scrambled egg Wheat toast Butter Whole milk Flintstone V/M	1 egg with fork 1 piece w/o crust 1 teaspoon 4 oz in cup 1 vitamin	25 minutes	Highchair in Kitchen
11 AM	Pediasure	4 oz. in bottle	10 minutes	Crib before nap

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Child's appetite:

- Child does not recognize hunger
 Child does not recognize satiety/fullness
 Child's appetite is consistent from day-to-day

Family Meals:

How many meals per week does your family eat together? _____

Where are your family meals eaten most often? _____

How many meals per week are eaten away from home? _____

Who is the primary person in the household who prepares most meals? _____

Growth Assessment:

Current weight: _____

Percentile for Weight: _____

Current Height: _____

Percentile for Height: _____

Please list any concerns you have with your child's growth: _____

Has your child been following their own growth curve or has their growth percentile changed in the last few months? Please explain _____

Bowel Movements: Regular Irregular How Often: _____

Type: Pebble-like Formed Loose

Number of wet diapers per day: _____

Sleep schedule (Wake, naps, bedtime): _____

SELF-CARE:

Bathes self: Independently Needs Assistance

Undresses self: Independently Needs Assistance

Dresses self: Independently Needs Assistance



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Is your child toilet trained: Yes No

If yes, at what age: _____

Bladder (daytime) Bladder (day and nighttime) Bowel

SENSORY HISTORY:

VESTIBULAR (Movement and gravity information). Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Rocks while sitting | <input type="checkbox"/> Jumps a lot |
| <input type="checkbox"/> Likes being tossed in the air | <input type="checkbox"/> Good balance |
| <input type="checkbox"/> Fearful of heights | <input type="checkbox"/> Fearful of movement |
| <input type="checkbox"/> Likes Merry-Go-Rounds | <input type="checkbox"/> Spins and Whirls more than others |
| <input type="checkbox"/> Gets car sick | <input type="checkbox"/> Prefers quiet play as opposed to active |
| <input type="checkbox"/> Enjoys being rocked: <input type="checkbox"/> Now <input type="checkbox"/> As an infant | |
| <input type="checkbox"/> No fear of movement or falling | |

Comments: _____

TACTILE (Touch information). Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Avoids messy things (mud, finger paints, etc.) | <input type="checkbox"/> Dislikes face or hands washed |
| <input type="checkbox"/> Irritated by cloth of certain textures | <input type="checkbox"/> Objects to being touched |
| <input type="checkbox"/> Dislikes unexpected touch | <input type="checkbox"/> Avoids using hands for extended periods |
| <input type="checkbox"/> Bangs head on purpose (now or in past) | <input type="checkbox"/> Pinches, bites, hurts self |
| <input type="checkbox"/> Mouths non-food objects | <input type="checkbox"/> Feels pain less than others |
| <input type="checkbox"/> Isolates self from others | <input type="checkbox"/> Strong like/dislike toward food textures |
| <input type="checkbox"/> Excessively ticklish | <input type="checkbox"/> Dislikes hair washing |
| <input type="checkbox"/> Dislikes nail cutting | <input type="checkbox"/> Wants to handle everything |
| <input type="checkbox"/> Seeks a lot of touch | |

Comments: _____

PROPRIOCEPTIVE (Muscle and joint information). Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Holds hands in strange positions | <input type="checkbox"/> Holds body in strange positions |
| <input type="checkbox"/> Good coordination with small items | <input type="checkbox"/> Walks on toes (or did when younger) |
| <input type="checkbox"/> Went from sitting to standing with little to no crawling | |
| <input type="checkbox"/> Crept on tummy rather than hands and knees | |
| <input type="checkbox"/> Leaps from one position to the next, unable to move slowly from one place to another | |

Comments: _____

AUDITORY: (Check all that apply)

- | |
|---|
| <input type="checkbox"/> Responds negatively to unexpected or loud noise |
| <input type="checkbox"/> Has difficulty paying attention when there are other noises nearby |
| <input type="checkbox"/> Misses hearing some sounds |
| <input type="checkbox"/> Seems confused as to the direction of sounds |



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- Seems to enjoy strange noises and/or makes loud noises
 Appears to be hard of hearing
 Enjoys music
 Has a diagnosed hearing loss
 Wears a hearing aid

Comments: _____

VISUAL: (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Reversals in copying | <input type="checkbox"/> Happier in the dark |
| <input type="checkbox"/> Looks very closely at pictures/objects | <input type="checkbox"/> Difficulty discriminating shapes or colors |
| <input type="checkbox"/> Resists having eyes covered | <input type="checkbox"/> Squints often |
| <input type="checkbox"/> Becomes excited when there is a variety of visual objects | |
| <input type="checkbox"/> Difficulty focusing on objects far away | <input type="checkbox"/> Difficulty focusing on close objects |
| <input type="checkbox"/> Wears glasses | <input type="checkbox"/> Difficulty maintaining eye contact |
| <input type="checkbox"/> Difficulty following objects across the room | <input type="checkbox"/> Sometimes shakes head awkwardly |
| <input type="checkbox"/> Difficulty following object tossed to him/her | |
| <input type="checkbox"/> Shifts head to one side in order to look at an object | |

Comments: _____

GUSTATORY-OLFACTORY (Taste and smell information). Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Acts as though all food tastes the same | <input type="checkbox"/> Chews on non-food objects |
| <input type="checkbox"/> Has unusual cravings for certain foods | <input type="checkbox"/> Dislikes food of certain textures |
| <input type="checkbox"/> Explores by smelling | <input type="checkbox"/> Discriminates odor |
| <input type="checkbox"/> Reacts negatively to smell | <input type="checkbox"/> Ignores unpleasant odors |

Comments: _____

SPEECH-LANGUAGE HISTORY CONCERNS (CHECK ALL THAT APPLY):

- Spoken Language/Expressive Language
 Comprehension/Receptive Language
 Articulation/Speech Sound Production
 Stuttering
 Social Skills

Other (please specify): _____

SCHOOL/DAYCARE/THERAPY INFORMATION:

Does your child attend school/daycare: Yes No

School/Daycare: _____ Grade: _____

School/Daycare Days: Part day (AM/PM) All day

Teacher: _____

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Has the teacher expressed any concerns Yes No

(If yes, please specify): _____

Has your child received prior therapy? (Please check all that apply):

First Steps School Outpatient facility similar to Sensory Solutions

Does your child have an IEP/IFSP/504 Plan: Yes No

If yes, please provide a copy to your therapist

If there are other concerns not covered in this form, please share: _____

Person completing this form: _____

Date: _____

-

-