FEEDING & SWALLOWING
CASE HISTORY INTAKE FORM

Chatty Child™
Speech & Occupational Therapy, PLLC

CHILDS INFORMATION

Child's Full Name _____

Child's Nickname(s) _____

_____

Child's Date of Birth _____

Chronological Age _____

Adjusted age (if applicable) _____

Street Address _____

City, State Zip _____

Home Tel _____

CAREGIVERS INFORMATION

Mother's Name _____

Mother's Occupation _____

Mother's Cell _____

Mother's Work Tel _____

Mother's Email _____

Father's Name _____

Father's Occupation _____

Father's Cell _____

Father's Work Tel _____

Father's Email _____

Alt Caregiver's Name _____

Alt Caregiver's Cell _____

325 Broadway - Suite 403, New York, New York 10007
tel/fax 347.491.4451 email chattychildny@gmail.com
www.chattychild.com

For Office Use Only:
○ PRIVATE ○ DOE ○ EI
○ SP ○ OT ○ BOTH
○ Added to Database
○ Scanned & Filed

Was the child breast fed?

Was child fed through a feeding tube? ☐ Yes ☐ No

If yes, for how long?

EATING HABITS

What does your child eat in a typical day? List main foods & amounts per meal.

Breakfast

Morning Snack

Lunch

Afternoon Snack

Dinner

Evening Snack

How long does it take for your child to finish a meal?

What are your child's favorite foods?

What foods does your child dislike?

In what position is your child most comfortable eating? Check all that apply.

☐ Highchair ☐ Chair at table ☐ Standing ☐ Lap
☐ Laying Down ☐ Other

What utensils have been introduced? Please indicate at what age.
Check all that apply.

☐ Pacifier _____ ☐ Bottle _____ ☐ Fingers _____
☐ Spoon _____ ☐ Fork _____ ☐ Sippy Cup _____
☐ Straw _____ ☐ Regular Cup _____ ☐ Other _____

Is any adaptive equipment being used during feedings?

If your child is not using a bottle, when did they transition to a cup?

Does your child self-feed?

At what age did child start self-feeding?

What kinds of food does your child eat regularly? Please indicate at what age.
Check all that apply.

- ☐ Breastmilk _____
- ☐ Formula _____
- ☐ Thin liquids _____
- ☐ Thickened liquids _____
- ☐ Pureed food ____
- ☐ Mashed table food _____
- ☐ Chopped table food ____
- ☐ Regular table food _____
- ☐ Other _____

If your child is eating solids, at what age was solid food introduced?

Does your child take any nutritional supplements?
If yes, please indicate product, amount & frequency.

How do you if your child is hungry?

How do you know when your child is full?

Is your child having trouble losing weight?

Is your child having trouble gaining weight?

Please check off any behaviors that apply to your child *during meals*:

- ☐ Choking
- ☐ Food or liquid coming out of nose
- ☐ Eats too much
- ☐ Eats too little
- ☐ Difficulty swallowing
- ☐ Trouble breathing
- ☐ Fussy, cranky
- ☐ Spitting out food
- ☐ Pushing food out
- ☐ Delayed swallow
- ☐ Gagging
- ☐ Crying
- ☐ Holding food in mouth
- ☐ Pocketing food in mouth
- ☐ Noisy breathing
- ☐ Wet quality to voice
- ☐ Gagging
- ☐ Reflux
- ☐ Vomiting
- ☐ Falling asleep
- ☐ Refusal to eat
- ☐ Head turning
- ☐ Mouth closing
- ☐ Stiffening
- ☐ Hyperextension
- ☐ Other behaviors

Does your child demonstrate negative behaviors during mealtime?
Please check all that apply.

- ☐ Throws food
- ☐ Spits food out
- ☐ Leaves table before done
- ☐ Messy eater
- ☐ Trouble with self-feeding
- ☐ Trouble with chewing
- ☐ Trouble with swallowing
- ☐ Refusal to eat
- ☐ Takes food from other's plate
- ☐ Other _____

Does your child still use a pacifier?

Does your child have difficulty with speech, feeding and/or movements with his/her mouth?

Does your child dislike being touched around his/her mouth?

Does your child drool? If yes, please indicate often, infrequent or occasionally.

What seems to help (or not help) your child during mealtime?