BRONSON

Affix Patient Label

Name:_____ Date of Birth:_____

Tell us about your child

Parent/Guardian's Name:_____

Pediatrician's Name:_____ Phone:_____

Who referred this child for this Team?

Birth History: ☐ Vaginal ☐ C-section ☐ Forceps ☐ Breech ☐ Induced ☐ Full Term

☐ Multiple Births ☐ Premature If so, How early?_____

Birth weight_____

Complications of pregnancy or delivery?_____

What is the primary language spoken in your home?_____

Does your child attend daycare? If yes, how often?_____

Is your child currently involved in an Early On (school-based) program?

_____

Who does your child live with? Siblings?_____

What are your feeding concerns for your child?_____

_____

What do you hope to accomplish in therapy?_____

_____

Developmental and Past Medical History

Are immunizations up to date ☐ Yes ☐ No

Does your child have any allergies? ☐ Yes ☐ No If yes, please explain and list_____

_____

What tests has your child had previously? ☐ Milk Scan ☐ PH Probe ☐ CT

☐ MRI ☐ X-Rays ☐ Head Ultra Sound ☐ Upper GI

☐ Swallow Study/Flexible Endoscopic Evaulation of Swallowing ☐ Nasal Endoscope

☐ Blood work/Labs ☐ Lower GI

What are the results from these tests?_____

_____

Is your child taking any medications? ☐ No ☐ Yes, please list_____

_____

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Please check any items related to medical history:

☐ Coordination Problems	☐ Balance Deficit	☐ Muscle tightness	☐ Stroke
☐ Heart/Cardiac Problems	☐ Speech Delay	☐ Feeding Problems	☐ Asthma
☐ High/Low Blood Pressure	☐ Cerebral Palsy	☐ Seizures	☐ Reflux
☐ Developmental Delay	☐ Cleft Palate	☐ Brain Injury	☐ Cancer
☐ Shunt/Hydrocephalus	☐ Cranial Bleeding	☐ Sleep Disorder	☐ Diabetes

Has your child ever been evaluated by:

☐ Neurologist	☐ Psychiatrist	☐ Audiologist	☐ Social Worker
☐ Speech Therapist	☐ Physical Therapist	☐ Genetic Specialist	☐ ENT
☐ Gastroenterologist	☐ Nutritionist	☐ Occupational Therapist	

☐ Other specialist_____

What are the results of the above evaluations?_____

_____

Developmental History:

Developmental Milestones: Please list when your child first:

Rolled:_____	Held Bottle:_____	Smiled:_____
Sat:_____	Used Spoon:_____	Babbled:_____
Walked:_____	Used Cup:_____	Crawled:_____
Reached for Toy:_____	Ate Solid Food:_____	

What activities does your child have difficulties with?

☐ Paying attention	☐ Sitting	☐ Rolling	☐ Standing
☐ Walking	☐ Crawling	☐ Picking things up	☐ Talking
☐ Eating	☐ Dressing	☐ Endurance	☐ Jumping
☐ Sleeping	☐ Swallowing	☐ School	☐ Memory
☐ Playing with others	☐ Understanding	☐ Calming	

Does your child:

☐ Avoid certain textures	☐ Avoid getting messy	☐ Dislike being hugged
☐ Bump into others a lot	☐ Dislike loud sounds	☐ Dislike bright lights
☐ Avoid walking barefoot	☐ Dislike spinning/swinging	☐ Like spinning/swinging
☐ Dislike hair being cut	☐ Dislike face being washed	☐ Difficulty calming self
☐ Dislike teeth being brushed		

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Does your child have a favorite toy?_____

Does your child have a favorite position to play in?_____

Are you or your physician worried about your child's growth pattern? ☐ Yes ☐ No

Current weight_____ Percentile_____ Head circumference_____ Percentile_____
Current height_____ Percentile_____

Does your child have or has had the following?

☐ Constipation issues
☐ Drools frequently
☐ Enlarged tonsils/adenoids
☐ Gags frequently
☐ Had tubes placed
☐ Had ear infections
☐ Have difficulty Swallowing
☐ Have a g-tube
☐ History of Asthma
☐ History of Bronchitis
☐ History of pneumonia
☐ History of respiratory infection
☐ Hoarse voice
☐ Is irritable a lot
☐ Pain related to eating
☐ Spits up frequently
☐ Stopped breathing
☐ Tonsils/adenoids removed
☐ Treated for reflux
☐ Vomits (how often)
☐ Wakes up at night frequently

Describe episodes of vomiting, spitting up and/or gagging: please list how often and when this happens:

_____

_____

Past and Current Mealtime Information:

Describe your child's early feeding history:

☐ Breasted what ages?_____ Problems?_____

☐ Bottle-fed Problems?_____

How much volume did your baby tolerate? At what ages?_____

_____

When did you begin pureed foods? (Stage 1 and 2)

_____

How did your child do with this transition?_____

How did your child do with the transition to Stage 3/ table foods? And at what age did you make this transition?

_____

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When and how did the feeding problems begin?_____

_____

Current Feeding Routine:

Does your child have a good appetite? ☐ Yes ☐ No

How often does your child eat and drink? What are his/her usual mealtimes and snack times?

_____

What foods/liquids does your child eat?_____

_____

Breakfast?_____

Lunch?_____

Dinner?_____

Snacks?_____

How are the foods prepared?_____

What do you use when feeding your child? (check all that apply):

☐ Regular Liquid ☐ Thick Liquid ☐ Prepared in blender

☐ Stage 1 or 2 foods ☐ Stage 3 foods ☐ Mashed table foods

☐ Soft table foods ☐ Hard table foods ☐ Meltable table foods

☐ Other_____

Which of these foods is preferred/easiest for your child to eat?_____

Which of these foods is hardest for your child to eat?_____

What do you use when feeding your child? (check all that apply):

☐ Breast ☐ Fork ☐ Bottle ☐ Fingers ☐ Cup ☐ Straw ☐ Spoon

Which can your child use independently?

☐ Fork ☐ Spoon ☐ Fingers ☐ Cup ☐ Straw ☐ Bottle

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Name:_____Date of Birth:_____

Does your child have favorite tastes? What are they?_____

_____

Does your child have favorite textures? What are they?_____

Does your child prefer certain temperatures?_____

_____

Who usually feeds your child?_____

Who else can feed your child?_____

Where is your child fed?_____

What is the average time it takes to feed your child?_____

Other information you would like us to have_____

_____

_____

_____

Have you or your child been a victim of domestic violence? ☐ Yes ☐ No

Are you afraid to return home? ☐ Yes ☐ No

Option:

The following individuals have my consent to pick up or accept phone calls regarding my schedule:

_____

Signature of Parent or Guardian:_____ Date: _____

Reviewed by:

Therapist Signature:_____Date:_____ Time:_____