Stony Brook Medicine

PEDIATRIC SPEECH PATHOLOGY
FEEDING-SWALLOWING HISTORY FORM

Name: _____
Date of Birth: _____

Reason for evaluation: _____
Previous Swallow Evaluation: □ No □ Yes □ Stony Brook □ Other: _____

Pregnancy/Birth History (check all that apply): □ Full term □ Preterm: _____ weeks gestation
Pregnancy: □ Uncomplicated □ Complicated: □ Tobacco/alcohol/drug use □ Other_____
□ Birth Complications: □ Breathing Problems □ Feeding Problems □ NICU

Developmental History:

Sitting/walking:	□ Within Normal Limits	□ Delayed Development
Trained for bowel/bladder:	□ Within Normal Limits	□ Delayed Development
Bottle/breast/spoon feeding:	□ Within Normal Limits	□ Delayed Development
Chewing solids:	□ Within Normal Limits	□ Delayed Development
Control of saliva/drool:	□ Within Normal Limits	□ Delayed Development
Speech production/understanding:	□ Within Normal Limits	□ Delayed Development

Therapy history: □ Physical Therapy □ Occupational Therapy □ Speech Therapy □ Feeding Therapy
□ Early Intervention/Developmental Program □ Preschool/Pre-K □ K-12 □ Special Education Class
Growth: Height/Weight: □ Within Normal Limits □ Delayed Development – if known, percentiles: _____
Pacifier Use: □ Yes □ No

Current diet/nutrition/hydration: Check all that apply □ Feeding tube □ Regular diet □ Cut up/soft foods
□ Finely chopped □ Puree □ Baby food □ Thin liquids □ Slightly thick liquids □ Nectar thick liquids
□ Honey thick liquids Liquids taken by: □ Bottle - type: _____
□ Sippy cup - type: _____ □ Regular cup □ Spoon: _____
□ Good appetite □ Fair appetite □ Poor appetite □ Recent weight loss - __# of lbs. over ___ weeks/mos.
□ Food allergies: _____ □ Other: _____
_____# meals/feedings per day Length of meal time: _____ minutes □ Assistance with meals

Past Medical History

Anxiety/Depression	□YES	□NO	Kidney Disorder	□YES	□ NO
Autism	□YES	□NO	Learning Disability	□YES	□NO
ADD/ADHD	□YES	□NO	Leukemia	□YES	□NO
Asthma/COPD	□YES	□NO	Intellectual Dev. Delay	□YES	□NO
Allergies	□YES	□NO	Pneumonia	□YES	□NO
Brain Cancer	□YES	□NO	Radiation Therapy	□YES	□NO
Bronchitis	□YES	□NO	Seizures	□YES	□NO
Cardiac Disease	□YES	□NO	Shortness of breath	□YES	□NO
Cleft Palate	□YES	□NO	Sleep Apnea	□YES	□NO
Cerebral Palsy	□YES	□NO	Speech/Lang Impairment	□YES	□NO
Cancer	□YES	□NO	Stroke (CVA/TIA)	□YES	□NO
Chemotherapy	□YES	□NO	Swallowing Problems	□YES	□NO
Diabetes	□YES	□NO	Surgery:	□YES	□NO
Gastric Reflux	□YES	□NO	_____		
Head/Neurological Injury	□YES	□NO	Tracheostomy tube	□YES	□NO
Hearing Loss	□YES	□NO	Visual Impairment	□YES	□NO
Voice Impairment	□YES	□NO	Ventilator Dependency	□YES	□NO

List medications or attach list:

 Reviewed by SBUH SLP _____ **Initials**

Name: _____
Date of Birth: _____

Please check any of the following specialists seen in the past: □ Physical or Occupational Therapist □ Ear Nose and Throat Specialist □ Eye Specialist □ Neurologist □ Psychiatrist/Psychologist □ Pulmonologist □ Cardiologist □ Neuropsychologist □ Speech/Language Pathologist □ Audiologist (Hearing Test)

Additional Information:

_____
_____
_____

Results will be sent to names/locations listed below if address or faxes are provided

Name	Address or Fax	Phone

Disclosure of healthcare information will only be provided if authorized by the patient or legal guardian except for known healthcare providers

Name	Relationship to patient	Address	Phone	Fax
Name	Relationship to patient	Address	Phone	Fax

I authorize the Department to disclose healthcare information to names above. Valid for one year.

Signature of □Patient □Parent/Guardian _____ Date: _____
Printed name of Parent/Guardian: _____

Reviewed by SBUH SLP_____ _____
Name/ ID number **date/time**

SLP Notes: