Stony Brook Medicine

PEDIATRIC SPEECH-LANGUAGE PATHOLOGY Name: _____
Feeding & Swallowing Case History Attachment Date of Birth: _____

Describe feeding/swallowing difficulty:_____
_____

Feeding History: □ Tube fed (age)_____ □ Fed by mouth (age)_____ □ Breast
□ Bottle/ Nipple type**:**_____ □Breast Milk □Formula**:**_____
Discontinued breast/bottle: □ NO □ YES (date/age)_____
Check all that your child drinks from : □ Cup □Straw □ Bottle
Current diet: □ Regular table foods □ Cut up table foods □ Soft solids only
□ All puree foods □ Baby food: circle one: stage 1 2 3
□ All liquids □ Thickened liquid only: **circle one**: nectar honey other

Easiest foods:_____
Difficult foods:_____
Favorite tastes:_____
Favorite textures:_____
Preferred temperature:_____
Please describe your child's appetite: □ Good □ Fair □ Poor
Current weight:_____ **Current height:**_____
Feeding position: □ Cradled in arms □ upright in arms □ upright in infant seat
□ upright in highchair □ upright in wheelchair □ other:_____
Length of meal: □ < 20 minutes □ 20-30 minutes □> 30 minutes
Time between feeding: □ 2 hrs. □ 3 hrs. □ 4 hrs. □ __meals per day □ other:_____
Does your child self feed? □ NO □ YES **Special utensils**? □ NO □ YES
If yes, please describe the utensils: _____
How do you give your child medication?_____

Does your child experience any of the following?

□ Gagging when eating
□ Choking when eating
□ Coughing when eating
□ Reflux of food/vomiting
□ Stiffening and arching back
□ Refusal of food/liquid
□ Food/liquid coming out of the nose
□ Difficulty chewing
□ Feeling of a lump in the throat when swallowing
□ Increased coughing when lying down
□ Frequent burping
□ Poor morning voice quality
□ Increased phlegm in the throat
□ Frequent throat clearing
□ Feeling of throat tightness
□ Throat soreness or burning sensation not related to illness
□ Coughing episodes not related to illness/ swallowing
□ Bad taste in the mouth (sour, acidic, metallic)
□ Increased throat/mouth dryness
□ Unpredictable/variable voice quality during the day

Any history of feeding/swallowing evaluation or therapy? □ NO □ YES
If yes, please provide us with the dates, name, location and phone number:_____
_____

Please write down any additional information you feel will help us understand your swallowing problem: _____
_____

Speech Pathologist's Notes: _____
_____