**Case history form – 6 months – 5 years**

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| Child’s name:  | Age: | Date: |
| Filled out by:  | Relationship to child:  |
| Referred by (if relevant):  |
| PARENT CONCERNS |
| What are your concerns about your child’s eating, feeding, nutrition or growth? |
| HEALTH SERVICES |
| What health/medical professionals are currently involved with your child? |
| Has your child even been seen by a health professional regarding their feeding? YES NOIf YES, please give details: |
| Have you seen a dietitian about your child before? YES NOIf YES, please give details: |
| SOCIAL HISTORY |
| Who lives at home with your child? |
| Does your child attend playgroup/child care/kindergarten etc? If yes please provide details: |
| BIRTH HISTORY |
| Length of pregnancy (weeks): |
| Were there any problems during pregnancy? YES NODetails: |
| Birthweight:  | Twin or multiple birth: YES NO |
| Did your child require admission to the special care nursery or intensive care unit after birth? YES NOIf YES, please give details:   |
| MEDICAL HISTORY |
| Does your child have any medical diagnosis or conditions (past or present)? (E.g. gastrointestinal issues such as reflux, vomiting, constipation; poor growth, cardiac or renal conditions; neurological conditions; learning disability etc) YES NOIf YES, please give details:  |
| Has your child ever been hospitalised or had any surgeries? YES NOIs YES, please list reason(s) and approximate date/ages: |
| Does you child have any allergies or intolerances? YES NOIf YES, please provide details: |
| What is your child’s current health like? (e.g. how often do they get sick, any ongoing issues?) |
| Current (or most recent) weight:  | Current (or most recent) length/height: |
| What has their growth been like since they were born? |
| How do you feel about your child’s size and shape? |
| Any relevant family history of medical, developmental, allergy or eating issues? YES NOIf YES, please give details: |
| DEVELOPMENTAL HISTORY |
| Did you child ever have any delays in developing motor, language or learning skills? YES NODetails: |
| When was you child toilet trained? (If applicable) |
| If toilet trained, do they still have ‘accidents’ (when, how often) |
| What is your child’s sleeping like currently? (e.g. do they wake, are they easy to settle?) |
| FEEDING HISTORY |
| Was/is your child breastfed or bottle fed?  | For how long? |
| Any problems with breast or bottle feeding? (e.g. weak suck, long feeds, low/oversupply, fussy at breast/bottle, frequent breast problems (e.g. blocked ducts/mastitis) |
| Was your child tube fed at any point? For how long? What type? (e.g. NGT, NJT, PEG) |
| At what age did your child start solids? |
| Any problems with the introduction of solids? |
| Did your child have difficulty with transitioning to lumpy, textured or chewy foods (e.g. gagging, refusing) |
| At what age did your child eat:  | Lumpy foods? | Finger foods? | Chewy foods? |
| When did your child’s feeding/nutrition concerns begin?Describe:  |
| CURRENT EATING/FEEDING |
| Where does your child eat meals at home? |
| Does your child eat on their own or with others? Who do they eat with? |
| Does your child:  | Spit food out? | Hold food in their mouth? | Vomit when eating? |
| What are your child’s preferred food and drinks? |
| What are your child’s non-preferred food and drinks? |
| Are there whole food groups that your child avoids? |
| If your child only eats a very limited range of foods (e.g. less than 20-30 foods), please list all the foods/drinks that they do accept. |
| How does your child behave at mealtimes?How do you respond? |
| Does your child refuse to eat? Under what circumstances? |
| Are mealtimes stressful? Please describe: |
| How long does each meal take? |
| Does your child display anxiety around food, drink or mealtimes? Please describe: |
| What have you tried to help your child with their feeding/eating problem? |
| Do you need to use distractions to get your child to eat (e.g. TV, iPad)? |
| SENSORY PREFERENCES |
| Does your child enjoy messy play (e.g. sand/dirt/playdough etc) YES NO |
| Does your child enjoy playing with or touching their food? YES NO |
| Are there any food/textures that your child will not touch? YES NO |
| Does your child dislike messy hands or face? YES NO |
| Does your child dislike having their teeth brushed? YES NO |
| Is your child very sensitive to certain smells or sounds? YES NO |
| Does your child prefer:  | Bland or strong food? | Smooth or crunchy texture? | Cold or hot foods? |
| DAILY ROUTINE |
| Please describe a typical daily routine including all mealtimes (e.g. breakfast, snack, lunch, snack, dinner….or other routine). Please include:* Time of each meal or snack
* Types of foods offered
* Approximate amounts usually eaten
* Sleep time, including any naps and times slept overnight.
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Thank you for taking the time to complete this form – it provides information about your child’s feeding/nutrition prior to their initial assessment.

Please return completed form to kathleen@feedingfoundations.com.au