**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 NO  If YES, please give details: | | | | | | | | | | | | | |
| Have you seen a dietitian about your child before? YES NO  If 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 NO  Details: | | | | | | | | | | | | | |
| Birthweight: | | | | | Twin or multiple birth: YES NO | | | | | | | | |
| Did your child require admission to the special care nursery or intensive care unit after birth? YES NO  If 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 NO  If YES, please give details: | | | | | | | | | | | | | |
| Has your child ever been hospitalised or had any surgeries? YES NO  Is YES, please list reason(s) and approximate date/ages: | | | | | | | | | | | | | |
| Does you child have any allergies or intolerances? YES NO  If 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 NO  If YES, please give details: | | | | | | | | | | | | | |
| DEVELOPMENTAL HISTORY | | | | | | | | | | | | | |
| Did you child ever have any delays in developing motor, language or learning skills? YES NO Details: | | | | | | | | | | | | | |
| 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. | | | | | | | | | | | | | |

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