TheraKids INC.

Specializing in Pediatric Speech, Language, Feeding, and Swallowing

Feeding, Swallowing, and Oral Motor History Form

Today's Date: _____

Child's Name: _____ Date of Birth: _____

Parents' / Legal Guardians' Names: _____
Home Address: _____ Home Phone: (____)_____
_____ Cell Phone: (____)_____
County: _____ Work Phone:(____)_____
Email Address: _____
Physical address listed above is for mom / dad / caregiver _____
Can we contact you via text / e-mail regarding your child's therapy schedule and follow-up with therapy appointments?
Yes **No**

Diagnosis(es):_____
_____

Medical Insurance Company:_____
Policy Number:_____
Who will be responsible for payments:_____
Emergency contact information:
Name:_____ Relationship:_____
Phone Number:_____

Child's Pediatrician:_____
Address:_____
Zip Code:_____ Phone:_____ Fax:_____
How long has your child been under this physician's care?:_____

Concerns for child/reason for evaluation:

____ Feeding: Child is not eating enough foods, is a picky eater, doesn't like certain textures of foods, is a messy eater, has trouble swallowing foods.

____ Oral Motor: Has oral ties, may not move mouth appropriately when eating, is very sensitive around face and mouth

What do you hope to gain from today's evaluation? _____
_____
_____
_____

When did you first notice this problem(s)? _____

Therapist's Notes:_____
_____
_____
_____
_____

1325 SE 25th Loop, Suite 102 Ocala, FL 34471 Phone: 352-368-7728 Fax: 352-368-3808
therakidsinc.com

Pregnancy, Labor, and Delivery:

1. List any problems or complications during pregnancy (i.e.: gestational diabetes, eclampsia, maternal seizures, accidents/injuries, etc.):
   _____
   _____

2. List all medications/drugs taken during pregnancy (i.e.: prenatal vitamins, medications for high blood pressure, medications for seizures, cocaine, heroin, etc.):
   _____
   _____

3. List any problems or complications during labor and/or delivery (i.e.: cord wrapped around neck, breech delivery, anoxia/"blue" at birth, respiratory distress, induced birth, limpness, stiffness, etc.):
   _____
   _____

4. Pregnancy: ___ Full Term ___Premature
   Length of Gestation:_____
   Length of total labor:_____ Difficult labor: __ Yes __No
   Delivery Type: __Vaginal __C-section If C-section, what type: __ Emergency __ Planned
   Child's birth weight: _____lbs. _____oz.
   Elaborate on above delivery complications:_____
   _____
   _____
   _____
   Length of hospitalization for child:_____
   Complications at birth:
   __Jaundice __Cyanosis __Congenital defects __Breathing Difficulties
   Other:_____

   Was there a need for:
   __Oxygen __Transfusions __Tube Feedings
   If so, please explain:_____
   _____

   Were there any feeding difficulties in infancy: __Yes __No
   Explain:_____
   _____

5. List any problems or complications your child had after birth, as well as any medical conditions/illnesses your child was/has been diagnosed with (e.g.: poor feeder, respiratory distress, seizures, etc.):
   _____
   _____
   _____
   _____

Therapist's Notes:_____
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Developmental and Medical History:

1. How old was your child when he/she:

Sat alone: _____ Stood: _____ Crawled: _____
Walked alone: _____ Dressed self: _____ Toileted:_____
Babbled: _____ Used first words: _____ Combined words: _____
Used sentences: _____ Fed self:_____

2. Currently, what is your child's main way he/she communicates?

____Crying/Whining _____2 & 3 word phrases ____ Making noises
____Complete sentences _____Gesturing/Pointing ____Single words
If less than 10 words, please list_____

3. Language(s) spoken in the home: _____

Does your child speak this language? YES NO
Does your child understand this language? YES NO
Does your child speak English? YES NO
Does your child understand English? YES NO

4. Is your child easily understood by:

You? YES NO **Other family members?** YES NO **People outside the home?** YES NO

5. Check all below that your child has a history of:

___ High fevers ___ Ear infections ___ Seizures ___ Mouth breathing ____Frequent colds
___ Hoarseness ___ Acid Reflux ___ Swallowing problems ___ Feeding problems
___ Constipation/Diarrhea
___ Allergies: __None __Seasonal __Food __Other
Please list all allergies, including foods:_____
_____
Other:_____

3. Child's general health at present: __Good __Fair __Poor

4. List any accidents / injuries / surgeries / major illnesses / diseases your child has incurred and their dates:

_____ _____
_____ _____
_____ _____
_____ _____

5. List all medications your child currently takes:

Medication	Dose (i.e.: mg)	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Has your child ever had his/hearing tested? YES NO
If YES:
Date:_____
Results_____
Does your child have problems with his/her hearing? If YES, please explain:
_____

7. Has your child ever had his/her vision tested? YES NO
If YES:
Date:_____
Results_____
Does your child have problems with his/her hearing? If YES, please explain:
_____

8. Has your child had any previous testing?

			DATE:	RESULTS:
MRI	NO	YES	_____	_____
CT	NO	YES	_____	_____
EEG	NO	YES	_____	_____
Developmental/Educational	NO	YES	_____	_____
Psychological/Psychiatric	NO	YES	_____	_____
Neurological	NO	YES	_____	_____

9. Has your child achieved skills and then lost them: __Yes __No
   Explain (what and when):_____
   _____
   _____

10. Does your child attend daycare or preschool? NO YES, _____ hours weekly
    Setting:
    ___ In-home daycare: How many children attend? ____ How many children his/her age? ____
    ___ Private daycare center: How many children in his/her "group?" ____
    Name of the center: _____
    ___ Pre-K through the public school system or private school: How many children are in the class? ____
    Name of the center: _____
    ___ Headstart: How many children are in the class? ____
    Name of the center: _____

11. With whom does your child spend his/her days? _____

12. What does your child do during the day? _____

13. List all special education/therapy services your child is **CURRENTLY** receiving (i.e.: speech/language therapy, OT, PT, early intervention, etc.):

Service	Provided by(ie: school/private)	Frequency(ie: 2 x week)	Duration(since age 4)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. List all other special education/therapy services your child has **RECEIVED IN THE PAST**, but is no longer receiving (i.e.: speech/language therapy, OT, PT, early intervention, etc.):

Service	Provided by(ie: school/private)	Frequency(ie: 2 x week)	Duration(since age 4)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. Has your child made progress in previous speech, language, and/or feeding therapy? YES NO
    Please explain: _____
    _____

Therapist's Notes:_____
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General Statements and Questions Regarding Your Child (please check all that apply):

1. During playtime my child:
   - _____ Does not seem very interested in toys.
   - _____ Explores toys.
   - _____ Typically plays with other children.
   - _____ Tends to play by him/herself.
   - _____ Shares toys.
   - _____ Takes turns.
   - _____ What is his/her favorite toy or activity?_____
   - _____ Other:_____
2. During the nighttime my child:
   - _____ Sleeps well throughout the entire night.
   - _____ Wakes up once in a while, but easily goes back to sleep.
   - _____ Tends to wake up 1-3 times per night, and requires attention.
   - _____ Sleeps some, but requires some sort of food/drink during the night.
   - _____ Sleeps some, but typically plays in the middle of the night.
   - _____ Snores when sleeping.
   - _____ Is an open mouth breather when sleeping.
   - _____ Other:_____
3. Regarding potty training my child is:
   - _____ Fully trained.
   - _____ Says when he/she needs to use the bathroom, but not fully trained.
   - _____ Indicates when his/her diaper is wet or dirty, but not fully trained.
   - _____ Seems interested in potty training, but not fully trained.
   - _____ Shows no interest in potty training.
   - _____ Other:_____

4. Regarding my child's attention:
   - _____ He/She seems to attend to me and most activities 80-100% of the time.
   - _____ He/She seems to attend to me and most activities 50-75% of the time.
   - _____ He/She doesn't attend to me but stays focused during other activities.
   - _____ He/She has difficulty attending at all times.
   - _____ His/Her average attending time to books and toys is_____
   - _____ Other:_____
5. Regarding my child's memory:
   - _____ He/She tends to remember 2-3 step directions.
   - _____ He/She tends to remember only one step directions.
   - _____ He/She does not follow through with any directions.
   - _____ He/She tends to ask for directions to be repeated.
   - _____ Other:_____

Therapist's Notes:_____
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Feeding History:

1. Was/is your child breast fed? NO YES If yes, for how long? _____
   Is he/she still breast fed? NO YES If no, when did he/she stop? _____
   Reason for stopping: _____
   Problems/Difficulties: _____
   If still breast fed, please fill in the following:
   _____ times a day, _____ounces every _____ hours
   How long is each breast feeding session? _____
   Is/Was your child followed by a lactation consultant? YES NO

2. Was/is your child bottle fed? NO YES If yes, for how long? _____
   Is he/she still bottle fed? NO YES If no, when did he/she stop? _____
   Reason for stopping: _____
   Problems/Difficulties: _____
   Current bottle and stage nipple being used:
   _____
   _____
   If still bottle fed, please fill in the following:
   _____ times a day, _____ounces every _____ hours
   How long is each bottle feeding?_____

3. At what age did you introduce baby food? _____
   Did your child handle it well? YES NO If no, please explain:_____
   How was the transition to other stages of baby foods?_____
   How was transition to finger foods?_____
   How was the transition to table foods?_____

4. Foods that have been or are currently eaten:

	Problems/Difficulties?		If yes, please describe:	Do they continue to eat these foods?	
____ Formula	YES	NO	_____	YES	NO
____ Pediasure	YES	NO	_____	YES	NO
____ Stage 1 foods	YES	NO	_____	YES	NO
____ Stage 2 foods	YES	NO	_____	YES	NO
____ Stage 3 foods	YES	NO	_____	YES	NO
____ Graduate meals	YES	NO	_____	YES	NO
____ Soft finger foods	YES	NO	_____	YES	NO
____ Crunchy finger foods	YES	NO	_____	YES	NO
____ Blenderized foods	YES	NO	_____	YES	NO
____ Mashed table foods	YES	NO	_____	YES	NO
____ Soft table foods	YES	NO	_____	YES	NO
____ Regular table foods	YES	NO	_____	YES	NO

5. Does/did your child drink from a cup? NO YES If yes, what type?
   ____ Regular ____ Sippy ____ Straw ____ Spill-proof valve ____ Other:_____
   Problems/Difficulties: _____

6. Please list types of food/drink your child currently eats/drinks during mealtimes:
   Breakfast: _____
   Lunch: _____
   Dinner: _____
   Snacks: _____

Therapist's Notes:_____
_____
_____
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_____

7. Does your child eat the any of the following foods? If so, please list the items in each category:
   Vegetables:_____
   Fruits:_____
   Grains/Carbs:_____
   Dairy:_____
   Proteins:_____
   Condiments/Sauces:_____
   Snack Foods:_____
   Drinks:_____

8. Does your child prefer specific **temperature** for his/her foods? (hot, warm, cold) YES NO
   If yes, please specify:_____
   _____
   Is there a specific temperature that your child avoids? YES NO
   If yes, please specify:_____
   _____

9. Does your child prefer specific **taste** in foods? (bland, salty, sweet, sour, spicy) YES NO
   If yes, please specify:_____
   _____
   Is there a specific taste that your child avoids? YES NO
   If yes, please specify:_____
   _____

10. Does your child prefer specific **textures** for his/her foods? (crunchy, chewy, soft, smooth) YES NO
    If yes, please specify:_____
    _____
    Is there a specific texture that your child avoids? YES NO
    If yes, please specify:_____
    _____

11. Does your child experience any problems during or after eating? (gagging, coughing, vomiting, reflux, excessive spit-up)
    YES NO
    If yes, please specify:_____
    _____

12. How does your child react when the food items that he/she **does not** eat can be smelled cooking, are near him/her, or are on your plate? _____
    _____

13. Are there any foods that you have not yet introduced? YES NO
    If yes, please specify:_____
    _____

14. How does your child react when new food items are introduced? Please give examples.
    _____

15. Will your child touch foods that they don't want to eat? YES NO
    If no, what does he/she do?_____
    _____

16. Does your child have any physical responses to foods when eating? (Circle all that apply)
    Watery eyes Red color around eyes or face Coughing Choking Gagging Throwing up Drools when eating
    Gurgly sounds while eating Food or liquid comes out of nose Gets pale or blue color around lips Gets tired from eating
    Breathes faster or harder when eating Burping excessively while eating Arches back after meals

17. How long does it take for your child to finish an average meal?_____
    Would you consider them a (circle one) FAST EATER SLOW EATER AVERAGE SPEED
    Would you consider them a (circle one) GOOD EATER NOT A GOOD EATER AVERAGE

18. Does your child feed him/herself or are you feeding them?_____
    If you are feeding them, is it because they can't do it, to "speed up things", or something else?_____
    _____

19. How does your child eat when they are doing it **themselves**? Does he/she use any utensils themselves?
_____
_____

20. Does your child eat typical "meals" or is it small amounts of food all day long?_____
If it is all day long, please describe the routine, as best you can:_____
_____
_____

21. How does your child handle the food in his/her mouth during meals? (Check all that apply):
_____ Tends to stuff food in his/her mouth
_____ Puts the next bite in his/her mouth before they've finished chewing the first
_____ Takes overly large bites
_____ Tends to nibble (small bites), or only clears a small amount off a spoon
_____ Chews/keeps food in their mouth for a long time, or tucks it into his/her cheeks
Other:_____

22. Please answer the following questions regarding your child during mealtimes:
My child participates in _____(number) meals a day.
My child will / will not sit for meals.
My child is seated in/at (high chair, booster seat, table)_____during mealtimes.
Does your child use extra activities to help him/her eat (watching tv or video, playing, etc)? YES NO
If yes, please specify:_____
_____
Does your child eat separately or with the entire family? _____
Describe your family's mealtime habits (when does your family usually eat, where do they eat, etc):_____
_____
Is the routine the same on the weekdays and weekends? YES NO
If no, please explain how it changes:_____
_____

My child does/does not display behaviors with **preferred** foods (please explain)_____
_____
_____

My child does/does not display behaviors with **non-preferred** foods (please explain)_____
_____
_____

23. At your child's most recent check-up, how was your child's weight described from their growth chart?
____ Average weight ____Low weight, but following a steady curve _____Low weight
____Failure to Thrive What Percentile?_____

25. Has your child's doctor expressed concerns about his/her weight? YES NO
If yes, what recommendations have they made to you? _____
_____

26. Is your child currently meeting his/her caloric needs? (please circle) YES NO

27. My child's current caloric intake is: TOO LOW AVERAGE TOO HIGH UNSURE

28. Has your child ever been fed by tube? YES NO
If yes, what type? OG NG NJ GJ G-tube
If yes, when?_____

29. Current feedings: (fill in all that apply)
Gravity ____ cc's over ____ minutes ____ x/day (times: _____)
Bolus ____ cc's _____ cc/hr x ____ hours ____ x/day (times: _____)
Drip ____ cc/hr x _____ hours Between _____ AM/PM to _____ AM/PM
Oral ____ meals/day Between _____ AM/PM to _____ AM/PM

Swallowing

1. Has your child ever had a swallow study? YES NO
   If YES:
   What were the reason(s) for the study?
   _____
   _____

   What was the outcome of the study?
   _____
   _____

   When was the study completed and where?
   _____
   _____

2. Has your child had any pulmonary issues associated with feeding? YES NO
   If YES, what are these problems?
   _____
   _____

Oral Mechanism:

1. Does your child have a history of tethered oral tissues? YES NO
   If **YES**:
   In what oral structures were restrictions present? (Circle all that apply)
   Upper lip Lower lip Cheek area
   Anterior tongue Posterior Tongue

   Has your child had remediation surgery for this? YES NO
   Date of surgery: _____
   Surgery completed by: _____
   Date of Follow-up:_____
   Did your doctor give you post-surgery stretches? YES NO

2. Does your child have tightness on one side or torticollis? YES NO

3. Has your child been diagnosed with plagiocephaly? YES NO
   If YES, is your child receiving any intervention in this regard? Please explain: _____
   _____

4. Does your child have a history of: (Circle all that apply)
   Drooling Mouth breathing Loss of liquid or food when eating/drinking Trouble chewing

5. Does your child have a history of or currently do any of the following (check all that apply):
   _____ Thumb/finger sucking At what age_____ Until what age_____
   _____ Using pacifier At what age_____ Until what age_____
   _____ Putting objects in mouth At what age_____ Until what age_____

6. Teethbrushing:
   a. Does your child brush his/her teeth independently or need your help?_____
   b. If you help them, do they enjoy having their teeth brushed?_____
   c. Do they bite down or chew on the toothbrush?_____
   d. Are they seen by a dentist? If yes, who?_____
   e. Have they had dental issues? If yes, please explain:
      _____
      _____

Family Information and History:

1. Past family history of: (please check) Who?
   - ___Late talking _____
   - ___Speech/fluency problems _____
   - ___Language problems _____
   - ___Cognitive impairment _____
   - ___Learning disabilities _____
   - ___Dyslexia _____
   - ___Psychological/psychiatric problems _____
   - ___Neurological problems _____
   - ___Autism _____
   - ___Genetic disorders _____
   - ___Hearing problems _____
   - ___Other _____

2. Does anyone in your family have a history of food allergies/sensitivities? YES NO
   If yes, please list:_____
   _____

3. List all people living in the home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Circle parents' level of education:
   - Mother: Grade school High school College 5+
   - Father: Grade school High school College 5+

5. Mother's current occupation/job: _____
6. Father's current occupation/job: _____

Other:

Please list any other information you feel is important for us to know:
_____
_____
_____
_____

Therapist's Notes:_____
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General Consent Form:

TheraKids, Inc. may need to contact, or be contacted by, other professionals who have seen or currently see/work with your child. The need for contact may occur due to these needs:

1. Obtaining previous medical or other professional records necessary for evaluation and/or therapy.
2. Discussing your child's evaluation and /or therapy in order to address concerns, recommend additional services, referral to other professionals, and/or to discuss the child's progress.
3. Releasing copies of the evaluation report or progress notes, including documentation to insurance companies.

I hereby consent to the release of all therapeutic records (including evaluations, daily progress notes, or other documents) to the following:

Child's Name:_____ Child's Date of Birth:_____
Your Name (print):_____ Relation to Child:_____
Your Signature:_____ Date:_____
Are you the legal guardian for this child? □ Yes □No If no, name of legal guardian:_____

(Please check each box that applies and print clearly)

□ Pediatrician Name:_____ Group Name:_____
Phone:_____ Fax:_____
Address:_____

□ Other Doctor Name:_____ Specialty:_____
Phone:_____ Fax:_____
Address:_____
Name of Facility:_____

□ Other Doctor Name:_____ Specialty:_____
Phone:_____ Fax:_____
Address:_____
Name of Facility:_____

□ Therapy Name:_____ Specialty:_____
Phone:_____ Email:_____
Name of Facility:_____

□ Therapy Name:_____ Specialty:_____
Phone:_____ Email:_____
Name of Facility:_____

□ Therapy Name:_____ Specialty:_____
Phone:_____ Email:_____
Name of Facility:_____

□ School Name of School:_____ Teacher/Therapist Name:_____
Phone:_____ Fax:_____
Address:_____

□ Family Members Name:_____ Relation to Child:_____
Phone:_____ Email:_____
Address:_____

Name:_____ Relation to Child:_____
Phone:_____ Email:_____
Address:_____

Appointment and Daily Schedule Form

Child's Name:_____ Date of Birth_____
Your Name:_____ Relation to Child:_____

Today your child is being assessed to determine/rule-out his/her need for therapy. If your child does qualify for therapy, we will need to arrange days and times with you that would be optimal for your child to attend therapy. Although it is not always possible for us to meet these exact days and times, we do try our best to accommodate your preferences.
Below, please list **ALL** days and hours (Monday-Friday) that your child is available. Please make sure to fill this out accurately taking into account any time your child may be in school or other therapies, may have special activities, and may continue to have the need for naps.

Day:_____ Times Available:_____
Day:_____ Times Available:_____
Day:_____ Times Available:_____
Day:_____ Times Available:_____
Day:_____ Times Available:_____

HIPAA – Notice of Privacy Practices

Along with this history form you were given a sheet with information regarding out privacy practices. Please fill out and sign below as confirmation that you were given this information.

I, (print name)_____, have received and read the following documents, and they were explained to me, as needed: *Notice of Privacy Practices, as required by HIPAA; Letter of introduction to TheraKids, Inc.*

_____ _____
Signature/Relation to patient **Date**

THANK YOU FOR YOUR CAREFUL ATTENTION TO THIS FORM.
This confidential information will be used to assist us in the evaluation of your child.