



Pediatric Feeding History Form

CHILD'S NAME: _____ DATE OF BIRTH: _____

1. Please explain, in your own words, what your child's current feeding problem is:

2. Was your child breast fed? From when to when _____
Was your child bottle fed? From when to when _____
Please describe your child's initial skill on the breast and/or bottle:

3. During these early feedings, did your child frequently arch, cry, spit up, gag, cough, vomit or pull off the nipple? Circle the behaviors shown and describe when they would happen, why, for how long:

4. Describe how the weaning process off the breast and/or bottle went and why the child was weaned:

5. At what age did your child transition to: Baby cereal? _____ Baby food? _____
Finger foods? _____ Transition fully to table food? _____
Please describe how these transitions were handled by your child, especially if any difficulties happened:



6a. List the foods that your child currently will eat and drink (put a star next to their favorites):

6b. List the foods your child refuses:

6c. List the foods your child is allergic to:

6d. Describe your child's mealtime:

Who typically feeds your child? _____

Who typically eats with your child? _____

What type of chair is used? _____

How long are meals typically? _____

Does your child use utensils or any type of special cups/bowls (describe)? _____

Are there any other activities going on at meals? What activities (describe)?

6e. What times does your child typically eat and what type (bottle, breast, solids)?

7. Has your child ever been on any type of special diet? _____

If yes, please describe type of diet, at what ages, why and what was your child's response:

8. How do you know your child is hungry or full?

9. Has your child lost or gained any weight in the last 6 months, and how much?

10. Would you describe your child's weight as (circle one): Ideal Underweight Overweight

11. Does your child have/had any of the following problems? Please describe:
Dental, frequent constipation, frequent diarrhea, vomiting, choking, gagging, coughing

12. Does your child take a vitamin supplement? Which one?

13. Describe how you, and your child feel after a feeding:

You:

Your child:

14. What other evaluations have been completed regarding your child's feeding difficulties and what were the results/what were you told?

15. What treatments have been tried for this problem, and what were the results?

16. How can we be most helpful to you and your child?

3 Day Diet History Form

Instructions:

You are being asked to record all foods and drinks eaten/ drank by your child for 3 days in a row. The following directions will guide you in filling out the form. You need to complete this history and you will need to bring it with you to your appointment.

1. Please fill out ALL the information at the top of the first page.
2. Please record the DATE and DAY of the week for each day. Record ALL food and drinks eaten along with the TIME your child ate or drank them. It is best to carry the history form with you and to record items immediately so that nothing is missed.
3. Include an EXACT description of the item and your best guess of the portion size of the amount eaten. Write the brand name of formula your child is on (i.e. Enfamil, Prosobee, etc.), what type of juice he/ she drank (i.e. apple, grape, etc.), any special recipes for drink mixtures your child uses, and any additions to foods (i.e. ¼ cup mashed potatoes + 1 Tbsp margarine). Be sure to include dressings, sauces, gravies, or anything extra.
4. It is suggested that you may wish to use measuring spoons and cups when serving your child for these 3 days to report the amounts eaten/ drank better.

Example:

Date	Time	Food/ Drink Item	Amount	Bottle	Cup	Finger	Spoon
Tuesday 6/1/10	4 pm	Gerber applesauce #2	1 ounce				✓
		White Bread	¼ slice			✓	
		Ham lunch meat	½ ounce			✓	
		Mayonnaise	1 tsp			✓	
		White grape juice	1 ounce			✓	
	7 pm	Similac Formula	4 ounces	✓			
9 pm	Pediasure with fiber	8 ounces			✓		



Parent/ Guardian Name: _____ Daytime Phone #: _____

Child's Name: _____ Date of Birth: _____

Vitamin or Mineral Supplement: ____ NO ____ YES Name & Amount: _____

Formula Mixing: Number of scoops: _____

Amount of Water: _____

_____ I put water in the bottle first then the formula powder.

_____ I put the formula powder in the bottle first then the water.

_____ The formula is liquid in a can and I do not add anything.

Date	Time	Food/ Drink Item	Amount	Bottle	Cup	Finger	Spoon

Date	Time	Food/ Drink Item	Amount	Bottle	Cup	Finger	Spoon

Date	Time	Food/ Drink Item	Amount	Bottle	Cup	Finger	Spoon

Date	Time	Food/ Drink Item	Amount	Bottle	Cup	Finger	Spoon

Adapted from Toomey & Associates (2005); Denver, CO