FEEDING
FOUNDATIONS

PO Box 56
Heidelberg West 3081

0439 380 306
kathleen@feedingfoundations.com.au
www.feedingfoundations.com.au

Case history form – 6 months – 5 years

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)	

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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?

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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