swallow function/feeding – patient information

Date:_____ **Patient's name:**_____ **Date of birth:**_____

During the first visit, we will discuss your answers on this form. This helps us decide what tests/procedures we need to do. Your comments are very important. If possible, please complete this information at home and bring it with you to your first session.

Thank you in advance for this information.

Please bring your referral and insurance information to your first visit.
If you have any questions or concerns before your visit, please feel free to call us.

Cook Children's Medical Center	Cook Children's South Rehab Clinic	Cook Children's Child Study Center	Cook Children's Mansfield Rehab	Cook Children's Northeast Rehab
682-885-7660	682-885-4063	682-885-2190	682-885-2200	817-347-2955

Your requests and thoughts:
Why is the patient having this test? _____

What do you want to know from this test? _____

Please list customs, religious beliefs or wishes that we need to know about: _____

_____

During treatment we may give you directions for practicing activities at home. Do you have a favorite way of learning new information? ☐ Pictures ☐ Writing ☐ Demonstration ☐ No Preference

Please list any other concerns that you would like us to know:_____

Along with your child's physical health, we would like to know about your child's mental health.

☐ Yes ☐ No Are there any family issues that might impact your child's care? If so, please share.

_____

☐ Yes ☐ No Have you seen any changes in your child's moods or behavior? If so, please share.

_____

Birth information:

☐ Yes ☐ No Was the patient born after a full-term pregnancy?
If no, how early? _____What was the patient's birth weight?_____

☐ Yes ☐ No Were there any complications during pregnancy?
If so, please describe: _____

☐ Yes ☐ No Were there any complications during delivery?
If so, please describe: _____

☐ Yes ☐ No Did the patient stay in the hospital after birth?
If so, why and for how long?_____

☐ Yes ☐ No Was the patient on mechanical ventilation after birth?
If so, why and for how long?_____

Developmental history:
Please check if the patient has had problems or delays in any of these areas:
☐ Vision ☐ Hearing ☐ Motor skills (i.e., rolling, crawling, walking)
☐ Speech ☐ Learning/school ☐ Playing with others ☐ Behavior
If any checked, please explain:_____

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Medical:

Is the patient allergic to any medicines or foods? Please list:_____

_____

_____

Please list all the doctors that the patient sees and for what reasons: _____

_____

_____

What medical condition(s) does the patient have? _____

_____

_____

Please list the medicines that the patient is currently taking: _____

_____

Illnesses:

Please check if the patient has had any of the following:

☐ Hospitalization	☐ Allergic reactions	☐ Reflux	☐ Tracheoesophageal fistula
☐ Pneumonia	☐ Surgeries	☐ Cancer/tumor	☐ Respiratory syncytial virus (RSV)
☐ Always Congested	☐ Tonsillitis	☐ Ear infections	☐ Bronchitis/bronchiolitis
☐ Floppy Airway	☐ Frequent colds	☐ Bronchoscopy	☐ Upper respiratory infections
☐ Cleft lip/palate	☐ Tracheostomy	☐ Vascular ring	☐ Breathing treatments
☐ Seizures	☐ Heart problems	☐ Failure to thrive	☐ Stridor/noisy breathing
☐ Head injury	☐ Mechanical ventilation	☐ Infection (meningitis, encephalitis)	
☐ Constipation	☐ Turned blue/quit breathing		

If any checked, please explain:_____

_____

Feeding history:

Has the patient had a swallow study or feeding evaluation before this appointment?

If so, when:_____ where:_____ results: _____

Recommendations:_____

_____

What does the patient eat/drink?

Thin liquids:	☐ Juice	☐ Water	☐ Milk			
Thick liquids:	☐ Nectar, syrup	☐ Honey thick	☐ Milkshake thick			
Food:	☐ Stage 1	☐ Stage 2	☐ Stage 3	☐ Mashed soft table food		☐ Regular table food
Drink method:	☐ Bottle	☐ Breast	☐ Sippy cup	☐ Open cup	☐ Straw	☐ Special Method
Food method:	☐ Spoon	☐ Finger foods		☐ Fork	☐ Special equipment	

Please explain any problems:_____

_____

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What foods/liquids and how much does the patient usually eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Does the patient have any of the following during feeding?

- ☐ Crying
- ☐ Coughing
- ☐ Breathing problems
- ☐ Gagging
- ☐ Congestion
- ☐ Gurgly, wet voice sounds
- ☐ Color changes
- ☐ Vomiting
- ☐ Sneezing and running eyes
- ☐ Spitting food out/refusing food

If any checked, please explain: _____

_____

_____

_____

How long does a meal time last? _____

Which types of foods are easiest? _____

Which types of foods are hardest? _____

Sensory:

Does the patient mind having his face, hands, or feet messy or dirty? ☐ Yes ☐ No

If yes, please describe: _____

_____

Does the patient tolerate:

- ☐ Yes ☐ No Tooth brushing
- ☐ Yes ☐ No Having face/hands wiped
- ☐ Yes ☐ No Having toenails/fingernails clipped
- ☐ Yes ☐ No Having a haircut

For children with G-buttons:

What is the patient receiving via G-button? _____

How often and how much at a time? _____

How fast is volume given? _____

What is child's reaction to G-button feeds? _____

Thank you for your information.

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