

Sierra Rehab & Wellness Center
PEDIATRIC SWALLOWING

Patient Name: _____ Date of Birth: _____ Age: _____

Explain your concerns regarding this child's feeding/swallowing: _____

When did you first become concerned? _____

How has the condition changed since your initial concern? _____

What has been done about this concern? _____

Are there differences in interactions during feeding among caregivers? Yes No

Has this child attended or currently attending any other therapies? Yes No

Which? _____

Does child refuse food? Picky eating? Yes No

Explain _____

Does child have preferences for taste, texture or temperature? Yes No

Does child experience state/mood fluctuations during meal time? Yes No

Does child have allergens in environment (pets, smoke, etc)? Yes No

Has this child been previously tube fed? Yes No

Reason: _____

Does child experience reflux, vomiting, or constipation? Yes No

Does child have a history of GERD? Yes No

Has child had a tracheotomy or been medically ventilated? Yes No

Does child experience difficulty breathing, apnea from lack of oxygen? Yes No

Does child have a history of Upper Respiratory Infections or Pneumonias? Yes No

Does child exhibit difficulty managing secretions (e.g. excessive drooling)? Yes No

Does child experience coughing, choking, wet/hoarse voice? Yes No

Does child have any difficulties with sleeping? Yes No

Does child have unusual behaviors at meal time? Yes No

Does child have a routine feeding schedule? Yes No

Does child follow motor planning directions (e.g. "open your mouth")? Yes No

Is this child difficult to manage (disobedient behaviors)? Yes No

Does child have difficulty with hand eye coordination? Yes No

Does child have vision problems (seeing, squinting, straining)? Yes No

Please explain other concerns with development that we may find helpful when treating your child:

If you have noticed a change in your child's state or behaviors specifically at meal time, what are they?

How do you respond to the behaviors?