COMMUNICATION&
FEEDING SPECIALISTS
• OF SOUTHEASTERN WISCONSIN •
CREATING PATHWAYS TO SUCCESS

ADULT FEEDING HISTORY FORM

Patient's NAME: ______________________ **DATE OF BIRTH: ________________**

✦Please explain, in your own words, your current feeding problem:

✦To the best of your ability, please describe your feeding at various developmental ages. It may be helpful to ask a parent or caregiver….

Young Child (6 mon to 5 yrs)

School-Aged Child (5 yrs-15)

Adolescent into Adulthood

✦Do you have a history of any early speech/language/social communication delays, if so please describe:

✦Do you have any current difficulties with speech/language/social communication, if so please describe:

✦Who Lives in your Household? (select all that apply)

- ☐ Spouse
- ☐ Children
- ☐ Parents
- ☐ Roommates

✦Are Your Parents Deceased or Living?

☐ Mother living ☐ Mother deceased ☐ Father living ☐ Father deceased

✦Marital Status:

○ Single ○ Divorced ○ Separated ○ Married ○ Domestic Partnership ○ Widowed

IF YOU EAT BY MOUTH (NOT TUBE FED), PLEASE ANSWER THE FOLLOWING QUESTIONS:

✦. List the foods that you currently will eat and drink (put a star next to your favorites). Please be specific as possible:

Meats/Proteins	Fruit	Vegetables	Grains/Carbohydrates	Others

✦ List the foods you do not eat and would like to learn to eat:

Meats/Proteins	Fruit	Vegetables	Grains/Carbohydrates	Others

✦ List the foods you are allergic/intolerant to:

✦Describe your mealtime:

Who typically eats with you? ____

Where do you eat? ____

How long are meals typically? ____

Are there any other activities going on at meals (e.g. tv, cellphone)?

What activities (describe)? ____

✦ What times do you typically eat?

✦ Are you or have you ever been on any type of special diet?

✦ Do you regularly feel hungry and/or full?

✦ Have you lost or gained any weight in the last 6 months, and how much?

✦ Would you describe your weight as (circle one): Ideal Underweight Overweight

✦ Do you have/had any of the following problems? If so, please describe:

Dental, frequent constipation, frequent diarrhea, vomiting, choking, gagging, coughing, acid reflux

✦ Do you take a vitamin supplement? Which one?

✦ Describe how you feel after a feeding:

✦ What other evaluations have been completed regarding your feeding difficulties and what were the results/what were you told?

✦ What treatments have been tried for this problem, and what were the results (please be specific)?

✦ How can we be most helpful to you?

MEDICAL HISTORY

It is very important to have as complete a medical history as possible. Please fill out the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include your age(s) if relevant, any diagnoses made, and any treatments that have occurred.

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	
3			Frequent Ear Infections (tubes?)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Anemia/blood disorder	
9			Kidney/Renal disorder	
10			Urinary problems/infections	
11			Hormonal problem	
12			Muscle disorder/muscle problem	
13			Joint or bone problems	
14			Fractured bones	
15			Skin disorder/skin problems (eczema)	
16			Visual disorder/vision problems	
17			Eye infections	
18			Neurological disorder	
19			Seizures or convulsions	
20			Stomach disorder/stomach pain	
21			Vomiting/digestion problems	
22			Failure to gain weight/feeding problems	
23			Constipation/diarrhea problems	
24			Dehydration episodes	
25			Hearing Loss/Ear disorder	
26			Significant accidents	
27			Head injuries or concussions	
28			Ingestion of toxins, poisons, foreign objects	
29			Major medical procedures (detail below)	
30			Chronic medications (for what? when?)	
31			Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	

✦ **HOSPITALIZATIONS AND/OR SURGERIES:**

List the dates of any hospitalizations and the reason. List the dates of any surgeries and the reasons.

1. ____

2. ____

3. ____

4. ____

PRESENT HEALTH STATUS: Most recent Height = __________ Weight = ________Date: ______

Please note any illnesses for which you are currently being treated, including their current medications:

____

____

List any current and past diagnoses or major illnesses (include dates)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

✦ **Allergies**

Please list anything you are sensitive or allergic to:

Foods:

Medications:

Environment:

✦ Do you have a history of any of these? (check all that apply) *

- ☐ Choking
- ☐ Police arrest
- ☐ Aggression
- ☐ Inpatient mental health treatment
- ☐ Anxiety
- ☐ Depression
- ☐ None of the above

Explain any checked above:

✦ **Major Traumas Have you had:**

Please list any major traumas you have experienced:

FAMILY MEDICAL HISTORY

Are there any of the following medical problems on either side of your BIOLOGICAL parents' families? If YES, please indicate on which side of the family, MOTHER or FATHER and explain WHO this is in relation to you. Please also explain if medications, surgery or hospitalizations were needed.

ITEM	NO	YES	DESCRIPTION	MOTHER'S OR FATHER'S SIDE	WHO?	EXPLANATION
1			Birth defects/Congenital disorder			
2			Neurological disorder or seizures			
3			Respiratory disease or tuberculosis			
4			Hormonal or Gland disorder			
5			Allergies - food or environmental (specify which for whom)			
6			Diabetes			
7			Stomach disease/disorder/problems			
8			Senses problems - vision, hearing, touch, taste, smell, balance			
9			Swallowing or feeding problems			
10			Attentional/learning problems			
11			Hyperactivity			
12			Alcohol/drug problems			
13			Psychological/nervous issues			

HEALTH AND LIFESTYLE HABITS

✦List any behaviors or lifestyle habits do you currently engage in regularly that you believe support your health:

✦List any behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits:

✦What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your goals and in adhering to the therapeutic protocols which we will be sharing with you?

✦Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

✦Hobbies:

- Exercise (what kind, how often):
- Sleep: # hours/night ________ Sleep well? _______ Well rested? ________
- Stress level (check one): High______ Moderate ______ Low ______

Major stressors:

✦Do you have a religious or spiritual practice? Yes No

Do you use?	Yes	No	In the Past	Frequency
Alcohol				
Tobacco				
Caffeine				
Recreations drug (type?)				

Have you ever been treated for?	Yes	No	When	Results of Treatment
Alcoholism				
Eating Disorder				
Substance Abuse				

Any other information you feel is important for us to know….

SPD/Star Center Sensory Processing Checklist

Adolescent/Adult:

___ I am over-sensitive to environmental stimulation: I do not like being touched.
___ I avoid visually stimulating environments and/or I am sensitive to sounds.
___ I often feel lethargic and slow in starting my day.
___ I often begin new tasks simultaneously and leave many of them uncompleted.
___ I use an inappropriate amount of force when handling objects.
___ I often bump into things or develop bruises that I cannot recall.
___ I have difficulty learning new motor tasks, or sequencing steps of a task.
___ I need physical activities to help me maintain my focus throughout the day.
___ I have difficulty staying focused at work and in meetings.
___ I misinterpret questions and requests, requiring more clarification than usual.
___ I have difficulty reading, especially aloud.
___ My speech lacks fluency, I stumble over words.
___ I must read material several times to absorb the content.
___ I have trouble forming thoughts and ideas in oral presentations.

I would like more educational materials on Sensory Processing?

___ *yes*

___ *no*

**While this checklist can't diagnose SPD, it can be a helpful guide to see if additional testing should be done. When filling out this checklist, think about behaviors/tendencies during the past six months.*

"What Is SPD?" *Star Center SPD*. N.p., n.d. Web. 29 Jan. 2015.