MARSHALL UNIVERSITY SPEECH AND HEARING CENTER
One John Marshall Drive, Huntington, WV 25755-2675
Phone: (304) 696-3641 / Fax: (304) 696-2986

Marshall University
Feeding and Swallowing Clinic
Pre-Clinic Questionnaire

Today's date: _____

Child's name: _____ Date of Birth: _____

Parent/Caregiver name: _____ Telephone: (Home) _____
(Cell) _____

Address: _____ Email: _____
_____

Child lives with: _____biological parents(s) _____adoptive parent(s) ____foster parent(s)
Other:_____

Number and age of siblings/others who live with child:_____
_____

Person completing the form: _____Relationship to the child _____

PRENATAL AND BIRTH HISTORY

Were there any complications during the pregnancy with your child? ___ no __ yes If yes, describe:_____

If there were medications taken during the pregnancy with your child, please list. _____
_____

Was your child: ____born on time ____ born early ____born late ___ is a twin
____ is a triplet ___ other_____

If born early or late, how many weeks early or late? _____

Any complications during or after birth? Was your child in the neonatal intensive care unit? If yes, why and for how long? _____
_____
_____

Has your child ever had a problem with being: _____ underweight _____ overweight ____ failure to thrive?
Is this a problem now? If yes, describe _____
_____

MEDICAL AND DEVELOPMENTAL HISTORY

Child's medical diagnosis/medical problems:_____
_____

Psychiatric or behavioral diagnoses/problems? ___Yes ____No If yes, provide information: _____
_____
_____

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Current medications and dosages: _____
_____
_____

Please answer these 2 questions if your child is 6 months of age or older:

- Can your child hold his head up for more than a few seconds at a time? _____
- Can your child sit without assistance on the floor or in a chair?
  _____

Please answer these 2 questions if your child is 18 months or older:

- Is your child able to stand or walk by himself? _____
- Is your child able to stand or walk in a stander, walker or with assistance? _____

Please answer these 2 questions if your child is under the age of 3 years of age or has developmental delays.

- Does your child put toys in his mouth when playing? _____
- Does your child attempt to bite soft toys? _____

Does your child have delays in any of these areas?:

- Physical Abilities (walking, moving, using hands): ____ has delays now. ____ had delays in the past.
  Describe delays: _____

Physical Therapy services: ____currently receiving. ____ never received. ___ received in past but not now. If receiving services now, what is the PT working on? _____
_____

Occupational Therapy services: ____currently receiving. ____ never received. ___ received in past but not now. If receiving services now, what is the OT working on? _____
_____

Does your child use: __wheelchair __walker ___stander ___ gait trainer
___ankle/leg/foot/braces ___ other

- Adaptive Abilities: (dressing, bathing, toileting, etc.) ____ has delays now. ____ had delays in past.
  Describe delays: _____
_____

- Cognitive Abilities (thinking, learning, solving problems) ____has delays ____ had delays in the past.
  Describe delays: _____

Services for cognitive delays: ____ receiving. ____ never received. ____ received in the past but not now. Describe current services: _____
_____

- Communication Abilities (speaking, listening, understanding speech and language)
  ____ has delays ____ had delays in the past. Describe delays:_____
_____

Speech Language Therapy Services: ____ receiving. ____ never received ____ received in the past but not now. If currently receiving services, what is the ST working on? _____
_____

Does your child communicate with: ___ communication device? ____ PECS ____ sign language
Other way of communicating: _____

- Social/Emotional Abilities (interacting with others, expressing feelings)
  ____ has delays. ____ had delays in the past. Describe delays: _____

_____

Services for social skills: ____ receiving ____ never received ____ received in past but not now.
If receiving services now, describe:_____
_____

Using the spaces below, write up to 2 additional services your child is receiving or has received in the past that have not been listed above. (Examples: behavioral therapy, autism therapy services (ABA), nutritional services, vision, or hearing services).

- _____ ____ receiving now ___ received in past.

Describe services and goals: _____
_____

- _____ ____ receiving now ___ received in past.

Describe services and goals: _____
_____

Does anyone in your child's family have a medical, psychiatric or developmental diagnosis that is similar to the diagnoses or problems your child has? If yes, please describe: _____
_____
_____

Briefly describe any surgeries your child has had. Include the location, date and surgeon if possible:
_____
_____

Has your child ever had a modified barium swallow (cookie swallow) test? If yes, when and where was the test done and what were the results? _____
_____

Does your child have allergies or intolerances to food or medications? – If yes please list._____
_____
_____

ADDITIONAL INFORMATION

Describe your child's sleeping habits_____

Is your child toilet trained? _____

Does your child hurt himself or hurt others? If yes, please describe: _____
_____

Any recent major changes or stresses in the family? _____
_____

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Please check all that apply:

Condition	***Now***	***In the past***
Reflux		
Asthma		
Sinusitis		
Frequent colds		
Bronchitis		
Hearing difficulties		
Chronic ear infections		
Constipation		
Diarrhea		
Pneumonia		
Aspiration Pneumonia		
Dark circles under eyes		
Bad breath		
Frequent hiccups		
Burping		
Eczema/rashes		
Poor sleep habits		

DIET, FEEDING SKILLS AND EATING HABITS

Has your child ever participated in a day-treatment or in-patient feeding program? If yes, when, for how long and what program? _____
_____
_____

Does your child receive feeding therapy from individual therapists? ___ yes ___ no
___ received in the past

If receiving feeding therapy now, who is providing the therapy? (Speech therapist or occupational therapist)
_____

What progress has your child made since starting feeding therapy?_____
_____

What are the current goals?_____
_____

What feeding techniques have been most successful with your child?_____
_____

Please check all that apply:

Does your child eat: ____ by mouth ____ by feeding tube ____ by parenteral nutrition (through a vein?)

If your child has a feeding tube, what kind? ___ NG (nasogastric) ____ G tube (into the stomach)

____ Jtube (into the intestines) ____ G and J combined

When and why was the feeding tube placed? _____

Please check all that your child receives through a tube:

____ Commercial nutrition formula	____ milk, soy milk, other milk	____ fruit juice
____ water	____ other beverages	____ blenderized food

If child has no feeding tube now but had one in the past: what kind of tube, at what ages did the child have it and for what reasons?

_____
_____

If your child has or had parenteral nutrition, when was it started and for what reason? _____
_____

Describe your child's appetite for the foods he likes? _____

In your own words, describe the foods and liquids your child eats and drinks by mouth and how often he eats these._____
_____
_____
_____

List your child's favorite foods **Foods he/she eats sometimes** **Foods he/she refuses**

Does your child have specific foods that are the only ones he will eat? (For example, brand specific foods- only eat Wendy's French fries or KFC mashed potatoes) If yes, please list,

_____
_____

Are there any foods that your child used to eat but no longer eats? If yes, please list and indicate how long they ate it and when they stopped: _____
_____

Does your child receive any vitamins or supplements? If yes, what kind and how often are they given?

_____

Is there anything else you would like the team to know regarding your child's diet or eating habits?

_____
_____

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Please check as many of the following as apply to your child:

___ Difficulty swallowing certain food textures

___ Difficulty swallowing some or all liquids

___ Difficulty transitioning from liquids to solids

___Dental problems

___ Difficulty taking food from a spoon

___ Difficulty with cup drinking

___ Difficulty keeping food in the mouth

___ Difficulty/unable to bite or chew

___Swallows some foods whole

___ Difficulty keeping the lips closed

___ Difficulty moving the tongue properly

___Drooling

___ Overstuffs mouth

___ Difficulty transitioning to foods with more texture

___Resists tooth brushing

___ Grimacing at food

___Still uses pacifier

___ Spits food out

___Refuses to eat with utensils

___Vomits (how often_____)

___Oral sensitivity

___ Brand specific food

___Dislikes getting hands wet or dirty

___ Color specific food

___ Avoids flavors

___ Shape specific food

___ Food jags

___High anxiety during meal times

___ Difficulty eating in new environments

___Gags at the sight

___Gags at the smell of food

___Gags at the sound of food

___ Gags at the taste of food

___Refuses to transition from bottle to spoon or cup

___Tantrums at mealtime

___ Retching/arching (when and how often_____)

___Food Selectivity

___Runs away from food

___Cyclical eating

___Turns head away from food

___Pushes food away

___Food refusal

___Throws food

___Refuses to eat at the table

___Only accepts favorite utensils/cups

___Eats non-food items

___ Only accepts certain amounts

___ Intolerance of feeding tubes

___ Holds food in mouth for long time

___Takes food from others

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SELF FEEDING SKILLS

Check as many as apply. If you have additional comments on any skill, please add them in the spaces provided.

Is your child able to?
___ Grasp small objects if placed in hand_____

___ Pick up small objects from table top using thumb and index finder _____

___Hold a spoon _____

___ Able to self feed_____
If yes, does child self-feed with: ____ hands ___ spoon ___ fork ___ knife

Can child hold: ___ bottle ___ sippy cup ___ regular cup
Can child drink from: __ bottle ___ sippy cup ___ straw ___ regular cup/glass

Does your child:

___ know when there is food in front of him?_____

___ see and recognize food or toys in front of him _____

___ use his eyes to help him reach for food or toys? _____

Does your child use any adaptive feeding equipment? If yes, please describe: _____

POSITIONING AND MEAL PATTERNS

Positioning during feeding: ___ lap ___ chair at table ___eat in front of TV
___ infant seat ___ wheel chair ___high chair ___booster seat

Does your child eat: ___ separate from the family ___ with the family ___ both

How do you know your child is hungry?_____

How do you know when your child is full? _____

Is child fed meals on a consistent schedule? ___yes ___ no ___ sometimes

Details: _____

Who typically feeds the child? _____

Average time to complete a meal? _____

Are your child's eating habits similar to other family members' eating habits? If not, please describe the difference
_____

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SERVICES AND SUPPORTS ***(please check all that apply)***

Services	Current Services	Past Services
Early intervention/Birth to Three		
Special needs class		
Regular class		
Home based special needs education		
Other		

Please provide the team with other specialists that follow your child

Specialist	Physician Name	Telephone
Geneticists (gene and chromosome specialist)		
Neurologist (brain and seizure specialist)		
Gastroenterologist (stomach and intestine specialist)		
Pulmonologist (lung doctor)		
Orthopedist (muscle, bone, joint doctor)		
Ophthalmologist (eye specialist)		
Developmental Pediatrician		
Psychologist (behavior specialist)		
Cardiologist (heart specialist)		
Psychiatrist (mental health specialist)		
Otolaryngologist (ear, nose and throat specialist)		
Endocrinologist (hormone and metabolism specialist)		
Other specialist or other information		

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Feeding and Swallowing Clinic
Psychology
Pre-Clinic Questionnaire

These questions will assist the psychologist plan appropriately for the needs of your child

PRESENTING PROBLEM / REFERRAL QUESTION

Please list the three biggest reasons (or problems) for which you are coming for an appointment:

1.) _____
2.) _____
3.) _____

HISTORY OF PRESENT PROBLEM:

Approximately how old was your child when you first noticed your child's problem? What did the problem look like then?

How has your child's problem changed throughout his or her growth?

What is your child's attitude toward his or her problems?

Has your child had any other behavioral or emotional problems in the past (even if they are not affecting him or her now)? Describe them.

Previous Therapy Experiences of Your Child (include family, school, psychotherapy, psychiatric medication)

Therapist Name Dates Clinic Name/ Phone Reason for Therapy Effectiveness

_____
_____
_____
_____

Previous Psychological Testing of Your Child

Evaluator Name Date Clinic/ School Name/ Phone Reason for Testing Findings

_____
_____
_____
_____

Has your child ever talked about hurting or killing himself or herself or another person? Describe.

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Has your child ever used or abused medication, illegal drugs, or alcohol? Describe.

MEDICAL AND DEVELOPMENTAL HISTORY

Current medications and dosages: _____
_____
_____

Past medications that your child has taken for behavior or psychological problems (list name only):
_____

Drug or Other Allergies: _____

Child's immunizations up to date? YES NO (If no, which ones are not? _____)

Has your child ever had any surgeries or hospitalizations? _____
_____

Child's Exposure to Poisons or Toxic Substances _____
_____

Has your child had any serious and/or life-threatening illnesses or injuries? _____
_____

How did the parents feel when they found out that the mother was pregnant? Was the child planned? ___
_____
_____

Please circle all that occurred during the mother's pregnancy with this child:

a. Smoking
(# of packs per day:_____)
b. Drinking Alcohol
(# of drinks per day:_____)
c. Marijuana Use
d. Cocaine/Crack Use
e. LSD Use
f. Other Street Drug Use
(What Drug(s): _____)
g. Physical abuse of mother
h. Extreme stress on mother
i. Major illness of mother
(Illness:_____)
j. Major injury of mother
k. Regular prenatal care

Other significant things or complications about pregnancy and delivery, please describe:
_____
_____

BIRTH HISTORY:

a. Child's weight at birth: _____ Type of birth: Vaginal C-Section
b. Premature birth? YES NO If premature, how many weeks into pregnancy at birth? _____
c. Problems/illnesses immediately after birth: _____
d. Admission to hospital/neonatal ICU: YES NO

At what age did your child?

Sit: _____ Say first word: _____ Say two-word sentences: _____
Crawl: _____ Toilet Trained: _____
Walk: _____ Learn to read: _____

Would you say that your child developed faster, slower, or at about the same rate as other children?

_____

Check all that apply to your child as a baby:

____Cuddly ____Curious ___Difficult to soothe ____Easy to put on a schedule
____Irritable ____Active ___Withdrawn ____Easily startled/overreactive
____Cried a lot ____Friendly ___Good sleeper ____Afraid of strangers
____Slow to warm up ____Tense/ "on edge

FAMILY HISTORY

Does anyone in the child's immediate or extended family have the following illnesses or problems? Include brothers, sisters, father, mother, grandparents, aunts, uncles, cousins?

	Y	N	Relationship (father, aunt, etc.)
Illness			
Depression			
Manic Depression			
Nervous Breakdown			
Psychiatric Hospital			
Delayed Reading			
Delayed Speech			
Mental Impairment			
Attention Problems			
Hyperactivity			
Heavy Drinking			
Drug Abuse			
Suicide			
Stealing			
School Phobia			
Epilepsy			
Felony Conviction			
Anxiety Disorder			
Bedwetting			
Aggressive Outbursts			
Schizophrenia/Psychosis			
Autism			
Eating Disorder			
Insomnia			
Any Genetic Disorder			
Other			

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Please indicate if the following have occurred in the family:

	Date(s)	Description/Comments
Parental Divorce		
Separation		
Marital Problems		
Domestic Violence		
Excessive Conflict		
Death of Parent		
Death of Sibling		
Death of Grandparent		
Alcohol Abuse		
Drug Abuse		
Move to New Home		
Physical or Sexual Abuse		
Significant Illness		
Other Changes		

How is discipline handled in the family? _____
_____

Who is most responsible for discipline? Mother Father Both Other_____

Describe your relationships with the following extended family members.

a. Father's Parents: Excellent Good Fair Poor
b. Mother's Parents: Excellent Good Fair Poor
c. Father's Siblings: Excellent Good Fair Poor
d. Mother's Siblings: Excellent Good Fair Poor
e. Child's Cousins: Excellent Good Fair Poor
f. Other:_____: Excellent Good Fair Poor

Family Religion: _____

Other Marriages or Live-In Relationships of Biological MOTHER (past and present; include marriage to biological mother, if divorced):

Partner's Name	Dates of Relationship	Children's Names	Reason for Divorce

Other Marriages or Live-In Relationships of Biological FATHER (past and present; include marriage to biological mother, if divorced):

Partner's Name	Dates of Relationship	Children's Names	Reason for Divorce

MAJOR STRESSES AND COPING STRATEGIES

List the three biggest stressors in your child's life right now.

a. _____
b. _____
c. _____

Are there any other major stressors that have occurred in your child's lifetime and had a lasting effect on him or her?

Has your child been sexually abused? YES NO If so, describe.

Has your child been physically abused? YES NO If so, describe.

Has your child been emotionally abused? YES NO If so, describe.

How does your child *usually* cope when under stress? (Check all that apply)

_____Tries to solve problem
_____Seeks information about problem
_____Comes to parents for help
_____Goes to friends for help
_____Gives up and accepts the problem
_____Jokes, makes light of the problem
_____Prays or asks God for help
_____Refuses to talk; "holds it in"
_____Other:_____

_____Ignores or pretends that is there is no problem
_____Becomes anxious and/or fearful
_____Becomes angry and/or throws tantrums
_____Takes a positive attitude toward the problem
_____Gets physically ill
_____Becomes manipulative or deceitful
_____Withdraws from others; tries to be alone
_____None of the above

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SOCIAL HISTORY

Check ALL that describe your child socially:
_____Other children seek him or her out for play
_____He or she seeks out other children for play
_____He or she prefers to play alone
_____Lots of children like him or her, AND few children dislike him or her
_____Lots of children like him or her, BUT lots of children don't like him or her
_____Other children pretty much ignore my child
_____My child fights a lot with other children
_____My child often plays cooperatively with other children

How many friends does your child have at home? _____
How much time does your child play with those friends per day? _____
How many friends does your child have at school?_____
How much time does your child play with those friends per day?_____

Does your child have a best friend**?** YES NO (If yes) What is the best friend's name?_____

How does your child get along with nonparent adults? (Check all that apply)

_____Friendly
_____Cooperative
_____Disobedient
_____Disrespectful
_____Better behaved than with parents
_____Adults like my child
_____Obedient
_____Other (describe)_____

How does your child get along with teachers/coaches?

_____Friendly
_____Cooperative
_____Disobedient
_____Disrespectful
_____Better behaved than with parents
_____Adults like my child
_____Obedient
_____Other (describe)_____

How does your child get along with brothers and sisters?
_____Protective of them
_____Aggressive/fights
_____Won't share things
_____Wants to be babied
_____Likes them
_____They like him or her
_____Jealous
_____Ignores them
_____Other (describe)_____

Has your child ever had a sexual relationship?

Has your child ever been arrested, accused, or convicted of a crime? What crimes?

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ACADEMIC HISTORY

Has your child ever been in nursery or day care? YES NO If so, what ages?_____

At what age did your child start kindergarten?_____ Start first grade?_____

Has your child ever been held back a grade? YES NO If so, what grade(s)?_____

Is your child in any of the following class placements?

_____Resource Room
_____Gifted Class (What subjects? _____)
_____Learning Disabled or Special Education Class (What subjects? _____)
_____Emotionally Handicapped (EH or BEH) Class

What are your child's grades in the following subjects? (Approximate if unsure.)

	This Year	Last Year	Best Year Ever (Yr:_____)	
Math	_____	_____	_____	(Yr:_____)
Reading	_____	_____	_____	(Yr:_____)
Spelling	_____	_____	_____	(Yr:_____)
Science	_____	_____	_____	(Yr:_____)
Social Studies	_____	_____	_____	(Yr:_____)
English	_____	_____	_____	(Yr:_____)
Other (describe)	_____	_____	_____	(Yr:_____)

What school subjects does your child like most? (Circle)

Math Reading Spelling Social Studies Science Other:

What school subjects does your child like least? (Circle)

Math Reading Spelling Social Studies Science Other:

How is your child's behavior in school? (Check all that apply)

_____Disobedient
_____Worried/tense
_____Not liked by children
_____Not liked by teachers
_____Overactive
_____Withdrawn/shy
_____Popular
_____Class clown

List changes in your child's school setting during his or her life. Why were these changes made? How did your child react?

Have any of the following happened to your child at school? (Write number of times.)

_____Suspended
_____Expelled
_____Special conference for behavior problems
_____Switched classes because of problems

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