MASSACHUSETTS
GENERAL HOSPITAL

SPEECH, LANGUAGE & SWALLOWING
DISORDERS AND READING DISABILITIES

Patient's Name:

Guardian's Name:

Date of Birth:

MGH #:

Birth History:

Full Term	☐ YES ☐ NO	If no, how many weeks was your pregnancy:
Complications	☐ YES ☐ NO	If yes, please explain:
Neonatal ICU Stay	☐ YES ☐ NO	If yes, how long was the ICU stay?
Adopted	☐ YES ☐ NO	If yes, age at adoption:

What are your specific questions/concerns about your child's feeding? ______________________________

____

When did you first notice a problem with feeding? ______________________________

____

Are you concerned about other aspects of your child's development? ☐ YES ☐ NO
(i.e. ability to sit, walk, talk)
If yes, please explain: ______________________________

____

Please list all of your child's medical diagnoses or problems: ______________________________

____

How is your child being currently fed? (Check all that apply) ☐ Mouth ☐ G-Tube ☐ J-Tube ☐ NG-Tube

If eating by mouth:

Is your child currently breastfeeding? ☐ YES ☐ NO

Is your child having difficulty transitioning to other textures? ☐ YES ☐ NO

Are there any problems with solids? ☐ YES ☐ NO

Difficulties biting or chewing? ☐ YES ☐ NO

Does your child like to eat? ☐ YES ☐ NO

Do you have any concerns regarding your child's behavior during meal times? ☐ YES ☐ NO

What foods are difficult for your child? ______________________________

What are your child's favorite foods? ______________________________

How much time does it take your child to complete an average meal? ________________________________

Other Medical History:

Are there any concerns regarding your child's growth?	☐ YES ☐ NO If yes, ☐ underweight or ☐ overweight
Does your child experience vomiting?	☐ YES ☐ NO
Does your child receive medications to prevent vomiting?	☐ YES ☐ NO Please list:
Does your child have breathing problems?	☐ YES ☐ NO Please list:
Does your child have known food allergies?	☐ YES ☐ NO Please list:

Oral-Motor/Swallowing:

Does your child drool?	☐ YES ☐ NO
Does your child pocket food in the cheeks (i.e. like a chipmunk)	☐ YES ☐ NO
Does your child over-stuff their mouth?	☐ YES ☐ NO
Does food or liquid escape through the nose?	☐ YES ☐ NO
Does your child choke on **solids**?	☐ YES ☐ NO
Does your child choke on **liquids**?	☐ YES ☐ NO

Sensory: Does your child exhibit any of the following behaviors?

Avoids using hands for feeding or messy play	☐ YES ☐ NO
Has difficulty tolerating or is overly sensitive to touch from others	☐ YES ☐ NO
Shows a strong preference for or avoidance of certain clothing	☐ YES ☐ NO
Avoids or cries easily during self-care tasks (i.e. face washing, tooth brushing)	☐ YES ☐ NO
Resists being cuddled or held	☐ YES ☐ NO
Craves being cuddled or held	☐ YES ☐ NO

Does your child receive Early Intervention (EI) services (birth to 3 years)? ☐ YES ☐ NO

If yes, please list the name of your Early Intervention and Service Coordinator:

____

____

What other therapy services are in place?

☐ Developmental Specialist ☐ Occupational Therapy ☐ Speech Language Therapy

☐ Physical Therapy ☐ Feeding Therapy ☐ Playgroup

☐ Intensive Services (e.g., ABA, Building Blocks/ESDM, DIR/Floor Time)

☐ Other: ____

Is your child enrolled in a daycare or school? ☐ DAYCARE ☐ SCHOOL ☐ NONE

School	**Type of Program**	**Days/Hours per week?**	**Language(s) spoken**	**Does your child receive specialized services at school?**
Name: **Town:** **Grade:**	☐ Regular ☐ Integrated ☐ Language-Based ☐ Substantially Separate ☐ Private School			☐ Individualized Education Program (IEP) *If yes, dates:* ________________ ☐ 504 Plan *If yes, dates:* ________________ ☐ None currently