Video Swallow Case History

Please complete this form before your child's Video Swallow.

Child's Name:______________________________________DOB:________________Sex:_____________

Person Completing Questionnaire:____

Relationship to child:____

What is the main concern regarding your child's swallowing?____________________________

____

____

Prenatal and Birth History:

During this pregnancy, did the child's mother experience any unusual illness, condition or accident: Yes or No

If yes, please provide information: ____

Was there drug/alcohol use during pregnancy? Yes or No If yes, please describe: ______________

Length of Pregnancy: ______________ Type of Delivery: Cesarean or Vaginal

Child's Birth Weight: ______________Hospital Stay following birth: ______________

Was infant in the Intensive Care Nursery? Yes or No For how long? ______________

Were any of the following present after birth?

Seizure Activity: Yes or No Difficulty regaining birth weight: Yes or No

Difficulty sucking/swallowing: Yes or No Need for oxygen: Yes or No

Medical Information:

Primary Physician/Practitioner: ______________________Phone: ( ) __________

Referring Physician: ______________________Phone: ( ) __________

Medical Diagnosis: ____

List Reason for Referral: ____

Has your child had any of the following tests?

Upper GI: When/Where:______________ Results:______________

Swallow Study: When/Where:______________ Results:______________

Endoscopy: When/Where:______________ Results:______________

Nuclear Med/Gastric Emptying: When/Where:______________ Results:______________

pH Probe: When/Where:______________ Results:______________

Has your child had? (Check all that apply)

Frequent colds: _______Bronchitis: _______ Asthma:_______ Bronchiomalacia: _______

Tracheaomalacia:_______ Laryngomalacia: _______ Bronchopulmonary Dysplasia: _______

Use of Oxygen: ______ Tracheostomy:_______ (if yes, date placed: ____________date removed____________)

Therapeutic History:

Does your child receive (please circle): Occupational Therapy Physical Therapy Speech Therapy

Where: ______________________ How often: ______________________

Therapist(s): ____

*Release of Information will need to be signed to provide information from this video to these individuals.

Nutrition and Feeding:

1. Does your child have difficulty gaining weight? Yes or No
2. Have there been any past or present nutritional concerns? Yes or No
3. Does or has your child have/had: (check all that apply)

   G-tube or J-tube: _______ Start: ________________ Stop: ________________

   Nasogastric tube: _______ Start: ________________ Stop: ________________

   Oral-Gastric tube: _______ Start: ________________ Stop: ________________

   Why were the tubes placed? ____

4. Check all that apply: Is your child drinking from:

Breast: Yes or No How often? _______________ How long on each breast? ____________________

Bottle: Yes or No How often? _______________ How many ounces per feeding? ________________

Length of time to take bottle? ________________ Nipple used? ________________

Cup: Yes or No How often? _______________ How many ounces per feeding? ________________

Does your child know how to use a straw? Yes or No

Do you need to assist with cup drinking? Yes or No

5. Please list food your child particularly likes, or are easy for him/her to handle: ________________________________

____

6. Please list foods your child particularly dislikes, or can not eat well. Describe why they are difficult for your child:

____

Developmental Information:

1. What position do you typically use for feeding your child? (circle all that apply):

   Sitting on your lap   Reclined in your arms   High Chair   Booster Seat

   Adapted Chair   Other:____

2. Can your child do any of the following? (Check all that apply)

Hold head up alone? Yes or No Since age:___________________

Roll? Yes or No Since age:___________________

Sit alone? Yes or No Since age:___________________

Crawl? Yes or No Since age:___________________

Pull to stand & cruise? Yes or No Since age:___________________

Walk alone? Yes or No Since age:___________________

3. Do you let your child get messy with foods while they are eating? Yes or No

   If yes, does your child enjoy this or fuss with being messy? Enjoy or Fuss

   Do you, as the parent, have trouble letting your child get messy with foods? Yes or No

4. Does your child suck on his/her pacifier? Yes or No
5. Does your child feed him/herself? Yes or No
6. On a scale of 1 to 10 (1 being the least stressed and 10 being the most stressed), how would you rate your level of stress in relationship to your child's feeding? (Please circle the appropriate number).

   (Least stressed) 1….2….3….4….5….6….7….8….9….10 (Most stressed)

*Thank you for your time and input. Please remember to bring this form with you to the appointment. We look forwarding to meeting your child and you. Please call with any questions: 515-241-8550.