Appendix A

MERKEL-WALSH & OVERLAND

Pediatric Case History Form

First Name			
Last Name			
Date Birth			
Address			
Home		Cell	
Referring Physician			
Date of Report			

Birth History

(please provide details where applicable)

Question	Yes	No
Were there any complications during pregnancy	☐	☐
Did you carry your baby full term?	☐	☐
Were there problems during delivery?	☐	☐
Did your baby require any special care after delivery?	☐	☐

Birth weight	
Percentile of weight	
Length/height	
Percentile of length/ height	
Apgar Score	

Medical History

Question	Yes	No
Does your child have a medical or educational diagnosis?	☐	☐
Has your child ever been on medication?	☐	☐
Is your child currently on medication?	☐	☐

Does your child have any of the following? *(check all that apply)*

☐	Frequent Colds	☐	Seasonal allergies
☐	Chronic Congestion	☐	Food allergies
☐	Asthma	☐	Hearing Issues
☐	Cardiac Issues	☐	Constipation
☐	Tracheomalacia	☐	Frequent spit-up
☐	Reflux/GERD	☐	Snoring
☐	Failure to thrive	☐	Bed-wetting

☐	Diagnosis of sleep apnea	☐	Recurrent middle-ear infections
☐	Laryngomalacia	☐	Diarrhea
☐	Frequent vomiting (after six months of age)	☐	Restless sleep

Dental History

Question	Yes	No
Has your child been seen by a dentist?	☐	☐
Does the dentist have any concerns about structure? *(If yes, check all that apply below)*		

☐	High Palate	☐	Teeth Grinding/Bruxism
☐	Cavities	☐	Plaque
☐	Lip-Tie	☐	Spaces between teeth
☐	Crowding	☐	Tongue-Tie
☐	Thrush	☐	Frequent spit-up

Feeding History

Was your baby breast- or bottle-fed?

☐	Breastfed	☐	Bottle-fed

How did you originally plan to feed your baby?

Question	Yes	No
Are there any concerns about nutritional status?	☐	☐
Do you have any concerns about feeding safety?	☐	☐
Has your child had a swallow study? (If so please attach the results)	☐	☐

Did you seek assistance with breastfeeding?	PCP	☐	Lactation Consultant (IBCLC)	☐	SLP	☐

Question	Yes	No
Was a lip-tie or tongue-tie identified?	☐	☐
Were you encouraged to see/discouraged from seeing a specialist?	☐	☐
Did you child have any difficulty breastfeeding/bottle-feeding (if yes, please check all that apply below)		

☐	Difficulty latching	☐	Reflux
☐	Coughing	☐	Gagging
☐	Crying	☐	Dribbling
Other:			

At what age did you introduce spoon-feeding?

Question	Yes	No
Did your child have any difficulty with smooth pureed food? (if yes, please check all the apply below)	☐	☐

☐	Coughing	☐	Spitting out food
☐	Vomiting	☐	Choking
☐	Gagging	☐	Food Refusal
Other:			

Question	Yes	No
Did your child have any difficulty with chunky pureed food? (if yes, please check all the apply below)	☐	☐

☐	Coughing	☐	Spitting out food
☐	Vomiting	☐	Choking
☐	Gagging	☐	Food Refusal
Other:			

At what age did you introduce solid foods?

Question	Yes	No
Did your child have any difficulty with dissolvable solids (ex., Cheerios, Puffs) (if yes, please check all the apply below)	☐	☐

☐	Coughing	☐	Spitting out food
☐	Vomiting	☐	Choking
☐	Gagging	☐	Food Refusal
Other:			

Question	Yes	No
Did your child have any difficulty with soft vegetables/fruits? (if yes, please check all the apply below)	☐	☐

☐	Coughing	☐	Spitting out food
☐	Vomiting	☐	Choking
☐	Gagging	☐	Food Refusal
Other:			

At what age did your child stop breast- or bottle-feeding?

Question	Yes	No
Did your child have difficult transitioning to a straw?	☐	☐
Did your child have difficulty transitioning to a cup?	☐	☐
Is your child on a special or restricted diet (e.g., glute-free, dairy-free) (If yes, please describe below)	☐	☐
	☐	☐
Does your child have a self-limited diet? (e.g., gluten-free, dairy-free) (if yes, please describe below)	Yes	No
	☐	☐
Does your child have food aversions? Please indicate difficulties with taste, texture, temperature, color, size and/or shape	Yes	No
	☐ ☐	☐ ☐
Are mealtimes longer than normal?	Yes	No
Would your child prefer to graze rather sit for a meal?	Yes	No

Please chart what your child eats (item and amount) in the following *Five-Day Baseline Diet*:

Five-Day Baseline Diet

	Day 1	Day 2	Day 3	Day 4	Day 5
Breakfast					
Snack					
Lunch					
Snack					
Dinner					
Snack					

Oral-Motor/Oral Habits

Question	Yes	No
Has your child had excessive drooling?	☐	☐
Does your child suck his/her thumb or digits?	☐	☐
Did your child use a pacifier? (if yes, enter how long below	☐	☐
Does your child exhibit open-mouth posture and mouth breathing?	☐	☐

Oral-Motor/Oral Habits

Is your child's speech intelligible to the familiar listener?

☐	<25%	☐	25-50%	☐	50-75%	☐	75%

Is your child's speech intelligible to the unfamiliar listener?

☐	<25%	☐	25-50%	☐	50-75%	☐	75%

Does intelligibility change as your child moves from single words to sentences?

Question	Yes	No
Do you have any concerns about sound production? (If yes, what sound(s) does your child have difficulty producing (circle sounds that apply)	☐	☐

If yes, what sound(s) does your child have difficulty producing (check sounds that apply)?

b ☐	m ☐	p ☐	w ☐	t ☐	d ☐	n ☐	l ☐	k ☐	
g ☐	h ☐	r ☐	sh ☐	ch ☐	j ☐	s ☐	z ☐	j ☐	
r blends	l blends	s blends	k blends	th	Vowels				

Therapy

Question	Yes	No
Has your child been seen a lactation specialist? If yes, please provide name below	☐	☐
Has your child been seen for feeding therapy (If yes, please provide name of treating therapist below	☐	☐
Has your child been seen for speech therapy? (If yes, please provide name of treating therapist below)	☐	☐

<u>Additional Information</u> (Feel free to use the back of this form.)