DEBRA DIET WORKS (518) 888-2929 | DebraDietWorks@gmail.com

Pediatric Feeding Parent Questionnaire

Today's date: _____ Email: _____

Person completing this form: _____

Child's name: _____

Date of birth: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone(s): (H) _____ (W) _____ (C) _____

Mother's name: _____ Father's name: _____

Physician name: _____

Physician address: _____

City: _____ State: _____ Zip: _____

Physician telephone: _____ Fax: _____

Is your child in preschool/primary school? Yes ☐ No ☐

If so, where? _____

Teacher's name: _____ Phone: _____

Has your child ever had a speech-language evaluation before? Yes ☐ No ☐

If so, indicate where, when and with whom: _____

_____

Has your child ever had a feeding evaluation or feeing therapy before? Yes ☐ No ☐

If so, indicate where, when and with whom: _____

_____

_____

Please list all other specialists who provide care to your child:

Name Specialty

_____

_____

_____

What are strong motivators (reinforcers) for your child? (e.g., food, toys, activities)

_____

_____

_____

_____

Birth/Developmental/Medical History

Has your child been diagnosed with any of the following?

GE reflux ☐ failure to thrive/slow growth ☐ developmental delay ☐

cardiac issues ☐ pulmonary issues ☐ neurologic issues ☐ esophagitis ☐ diarrhea ☐

constipation ☐ autism/PDD ☐ genetic/chromosomal abnormality ☐

cleft lip/palate ☐ mental health ☐ other (please specify)_____

Please list your child's current medications: _____

_____

_____

Has your child had any of the following medical tests done?

upper GI series ☐ endoscopy ☐ modified barium swallow study ☐ allergy testing ☐ milk scan ☐

genetic testing ☐ other (please specify)_____

Were there any illnesses/injury/complications during pregnancy or birth? If so, please describe._____

_____

Describe any difficulties with feeding that your child had as an infant (sucking, weight gain, sleeping cycles, temperament)._____

_____

How was your child fed as an infant? breast ☐ bottle ☐ tube fed ☐

How long did your child receive breast milk? _____ Formula? _____

How many infant formulas did you use?_____

At what age did your child eat from a spoon?_____

Describe any difficulties regarding your child's transition from bottle to finger foods/spoon feeding:_____

_____

Does your child have food allergies? Environmental allergies? If so, please list:

_____

_____

Current Feeding Concerns

Child's Weight:_____ Height_____

How would you describe your child's weight?: Ideal ☐ Underweight ☐ Overweight ☐

Is your child on any special diet? (Kosher, glutein-free, etc.):_____

_____

Does your child take any nutritional supplement? (list product, amount, frequency):_____

_____

Has your child seen a nutritionist or dietician? _____

If so, what were the recommendations?_____

_____

Does your child exhibit **difficulty** with any of the following during mealtime?

- ☐ drooling
- ☐ continuous sucking/poor sucking
- ☐ biting (ability to bite off pieces of food)
- ☐ chewing
- ☐ lip control (keeping mouth closed)
- ☐ swallowing
- ☐ teeth grinding
- ☐ vomiting/regurgitation
- ☐ coughing
- ☐ gagging
- ☐ food or liquid coming out of nose
- ☐ tongue control (tongue thrust, poor mobility
- ☐ hypersensitivity to textures, temperature, spoon

other (please specify)_____

Does your child exhibit any of the following **behaviors** during meal time?

☐ throws food	☐ refuses food	☐ spits food
☐ messy eater	☐ cries/screams	☐ leaves table before finished
☐ only eats certain foods	☐ takes food from others	☐ overeats (stuffs mouth)
☐ holds food in mouth	☐ tries to get out of seat	☐ gags/coughs
☐ vomits	☐ falls asleep or fatigues with meals	

other (please specify)_____

How is your child seated during mealtime? (regular chair, high chair, booster seat, standing, etc.)

_____

Are their feet supported while they are eating? (touching the ground, or supported by a foot rest)

_____

Does your child feed themselves? Yes☐ No☐ What utensils are used? Fork☐ Spoon☐ Fingers☐

How are liquids presented? Bottle☐ Regular cup☐ Sippy cup☐ Straw☐ Cuti☐ out cup☐

Other:_____ How do you know when your child is hungry?

_____

How do you know when your child is full?_____

How many times a day is your child fed?_____

How long does it take your child to complete a meal? _____

Does your child eat more/less when they are in different environments? (e.g., home versus grandparent's house)_____

Do you feel your child likes to eat? Yes☐ No☐

Describe the sequence in which food is offered to your child (e.g., liquids always first, etc.)_____

_____

As a parent, what strategies or techniques have you been trying independently to assist your child in eating? What do you do when your child does not eat appropriately?

_____

_____

_____

_____

Food consistency: Check all that are currently applicable:

	Does eat	Can eat	Never eats	Can't eat	Refuses	Not tried
Liquids/Soups	☐	☐	☐	☐	☐	☐
Baby Food	☐	☐	☐	☐	☐	☐
Creamy foods (ice cream, yogurt)	☐	☐	☐	☐	☐	☐
Blenderized/Pureed table food	☐	☐	☐	☐	☐	☐
Mashed table food	☐	☐	☐	☐	☐	☐
Chopped table food	☐	☐	☐	☐	☐	☐
Regular table food	☐	☐	☐	☐	☐	☐
Soft table food (pancakes)	☐	☐	☐	☐	☐	☐
Crisp foods (crackers, toast)	☐	☐	☐	☐	☐	☐
Chewy foods (meat)	☐	☐	☐	☐	☐	☐
Crunchy foods (carrots, celery, pretzels)	☐	☐	☐	☐	☐	☐

List any foods **consistently** accepted in the following categories:

Fruits:_____

Meats:_____

Breads/Cereals:_____

Vegetables:_____

Dairy products:_____

Sweets:_____

Snacks:_____

Beverages:_____

What would you like to see your child eat? _____

_____

Is there anything else you want me to know about your child regarding feeding or swallowing?

_____

_____

_____

_____

_____

_____

_____

_____

Is there anything else you would like me to know about your child?_____

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Five Day Food Journal- Include all liquids and solids. <u>Indicate amounts the child ate/drank (ounces).</u>

Child's name:_____ Week of:_____

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