Feeding Disorders Questionnaire

DEMOGRAPHICS

Child's Name:
Date of Birth:
Parent's Name/s:
Address:
Phone Number:
Feeding/eating concerns: **Family goals for child's feeding/eating:**

Previous individuals who provided assistance with the feeding problem:
Name(s) of persons or agencies:
Address:
Phone Number:

Current Day Care or School Placement (if applicable):
Address:
Phone Number:

Medical and Developmental Diagnoses:

Medical History: Check below and describe if it's a problem for your child

- **Reflux, eosinophilic esophagitis?** ____
- **Delayed emptying, slow motility?**____
- **Feeding tube dependence?**____

- **What are bowel movements like?** ____
- **Diarrhea or constipation?**____

- **Ear infections? If so, when & how often?**____________________________________
- **Upper respiratory infections?** ____
- **Pneumonia** ____
- **Aspiration** ____

Food Allergies:

Dietary Requirements or Restrictions?

FEEDING HISTORY

1. **Was your child ever: Bottle fed?** *Y or N* **Breast Fed?** *Y or N* **Both?** *Y or N*
2. **Did your child have trouble adjusting to breast feeding or formulas? If yes, please explain.** ____

   ____
3. **Were any of the following tube feedings Used?** *Y or N (please circle)*
4. **G-tube J-Tube NG-Tube NJ-Tube**
5. **When did you first notice that your child had a feeding problem?**________________
6. **How old was your child when <u>baby foods</u> were introduced?**________________
7. **How old was your child when <u>table foods</u> were introduced?**________________
8. **How did s/he respond?** ____
9. **Has your child had any procedures such as a swallow study or an endoscopy?**

   ____

CURRENT FEEDING PRACTICES

1. **Where does your child eat? (Please circle all that apply)**

   High Chair Booster Seat Lap Laying down

   Table/Chair Walking around Other:
2. **Who does your child eat with?** ______________________________
3. **How long do meals last?** _________
4. **Describe your child's appetite on a scale of 1 (poor) to 5 (eats too much).**__________
5. **How many meals and snacks a day does your child typically eat?** ________________
6. **Are they scheduled?** ____________

7. Mealtime Schedule: Please indicate mealtimes, and amounts of foods typically eaten

Meal	Time	Typical Foods and Amounts
Bfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

8. What does your child drink each day?____

9. How much? ___________________________

10. Are foods and drinks restricted or available when your child asks? _______________

11. Tube Feeding Information - if applicable

Current Tube type:	
Percent of daily calories via tube:	
Type of Formula:	
Bolus or Continuous:	
Vomiting or other problems with tube feedings:	

12. Tube Feeding Schedule: Please indicate times and amounts of tube feedings. If applicable

Times	Amount

FOOD PREFERENCES AND MEALTIME BEHAVIORS

1. At what point does your child start to refuse foods- visual/sight, smell, touch, taste? _

____

2. Can your child tolerate nonpreferred foods on his/her plate? On the table? ________

3. Does your child show interest in other people's food? ____________________________

4. **Does your child have any texture preferences – dry, crunchy, soft, wet, etc? _______**

____

5. **Does your child eat the same or different across settings – restaurant, school, friends or families' house? ____**
6. **What does the child do when a nonpreferred food is offered?____________________**

____

7. **What do you do when your child refuses?____________________________________**
8. **What have you tried to do in order to get your child to eat?**

Toys TV Talking/singing Offer preferred foods, toys, activities

Time out Remove privileges Mix or sneak nonpreferred foods in to favorites

Cook only preferred foods Allow child to eat whenever hungry (graze)

9. **Mealtime Behavior Checklist: Please circle all behaviors that your child exhibits during mealtimes:**

Spits food out	**Pushes food away**	**Turns Head**	**Keeps mouth shut**
Screams/Cries	**Overstuffs**	**Leaves the table**	**Holds food in mouth**
Eats too slow/fast	**Throws food**	**Tantrums**	**Other:____________**

10. **On a scale from 1 (pleasant meals) to 10 (very stressful) how stressful are meals?___**

ORAL MOTOR AND SELF FEEDING SKILLS

1. Oral Motor Status: Please circle any items below that are a problem during meals

Gagging	**Coughing**	**Poor suck**
Trouble Chewing	**Tongue thrust**	**Moving tongue side to side**
Difficulty drinking	**Difficulty Swallowing**	**Difficulty biting off food**
Loses food/liquid from mouth	**Poor lip closure**	**Drooling**

- **Do above problems occur with all foods or just certain types or textures?________**

  ____
- **Has your child ever had difficulties with swallowing that require thickened liquids or blenderized purees? Y or N Currently or in the past?____________________**

2. Have you ever had to do the Heimlich on your child because s/he choked?____________

3. Food Textures: Check the food textures your child currently eats:

- **Stage 1 or 2 baby food**
- **Stage 3 baby food**
- **Pureed table food - smooth**
- **Pureed table food – with lumps**
- **Wet Ground (like meat sauce)**
- **Mashed table food**
- **Meltable solids (cheese puffs)**
- **Soft solids (bananas, mac and cheese)**
- **Crunchy foods (hard cookie, raw vegetables)**
- **Chewy foods (meat, candy, granola bar)**

4. Do you have any concerns with your child's teeth?________________________________

5. Describe your child's self-feeding skills:

My child only uses her/his fingers to eat. *Y or N*
My child feeds himself but needs my help. *Y or N*
My child is independent in all areas of self-feeding. *Y or N*

- **Which utensils can your child use with or without help?** ***(please circle all that apply and mark an "H" next to the items s/he needs help with)***

Spoon	**Fork**	**Sippy Cup**	**Baby Bottle**
Straw	**Open Cup**	**Water bottle**	

6. Current Therapies: List where, therapist's name, how long and how often. Specify if any of the therapists are working on feeding.

- **Speech therapy:____**
- **Occupational Therapy: ____**
- **Physical Therapy:____**
- **Nutrition (EI): ____**
- **Special Education (EI): ____**

Additional comments or concerns

____
____
____
____
____

Food Preference Checklist

Child's name ____

Is your child on a special diet? ______________________________

Food Allergies ____

Food Restrictions ______________________________________

Please circle all foods your child eats and label any specific brands.

Starches:	Bread	Spaghetti	Cereal – List:
	Oatmeal	Rice	Waffles
	French fries	Noodles	Pancakes
	Mashed potatoes	Macaroni & cheese	French toast
	Baked potato	Corn	Muffins
Fruits:	Orange juice	Fruit cocktail	Orange
	Apple juice	Peach	Banana
	Grape Juice	Pear	Strawberries
	Watermelon	Pineapple	Apple
	Cantaloupe	Applesauce	Dried Fruit
Vegetables:	Green beans	Lettuce/salad	Spinach
	Carrots	Broccoli	Tomatoes
	Peas	Peppers	Sweet potato
Milk/Dairy:	Milk – Type	Soy/Almond Milk	Pudding
	Chocolate/Flavored Milk	Yogurt – type	Cheese
	Ice Cream		
Meat/	Chicken	Fish	Eggs
Protein:	Chicken nuggets	Fish sticks	Grilled cheese
	Hamburger	Sausage	Peanut butter
	Ham	Pork	Nuts
	Roast Beef	Hot Dogs	Other:
	Turkey	Steak	
Mixed	Pasta with sauce	Pizza	Sandwiches
Textures:	Tacos/burritos	Casseroles	Other:
Extras:	Margarine	Mayonnaise	Syrup
	Jelly	Salad dressing	Mustard
	Ketchup	Cream cheese	Other:
Snacks:	Cookies	Pretzels	Water
	Chips	Crackers	Soda
	Poptarts	Goldfish	Kool-aid

Brief Assessment of Mealtime Behavior In Children

Date:____________________

Think about mealtimes with your child over the past 6 months. Rate the following items according to how often each occurs, using the following scale:

Never/Rarely	Seldom	Occasionally	Often	At Almost Every Meal
1	2	3	4	5

Then, circle **YES** if you consider the item to be a problem or **NO** if you think it is not a problem.

	How often did it occur?	Do you consider this a problem?
My child turns his/her face or body away from food.	1 2 3 4 5	YES NO
My child cries or screams during mealtimes.	1 2 3 4 5	YES NO
My child is aggressive during mealtimes (hitting, kicking, scratching others).	1 2 3 4 5	YES NO
My child displays self-injurious behavior during mealtimes (hitting self, biting self).	1 2 3 4 5	YES NO
My child is disruptive during mealtimes (pushing/throwing utensils, food).	1 2 3 4 5	YES NO
My child closes his/her mouth tightly when food is presented.	1 2 3 4 5	YES NO
My child is willing to try new foods.	1 2 3 4 5	YES NO
My child dislikes certain foods and won't eat them.	1 2 3 4 5	YES NO
My child prefers the same foods at each meal.	1 2 3 4 5	YES NO
My child accepts or prefers a variety of foods.	1 2 3 4 5	YES NO
My child eats mostly pureed foods.	1 2 3 4 5	YES NO

Therapist use only:

- o Pre
- o Post

ID#______________________