



Pediatric Feeding Parent Questionnaire

Today's date: _____

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 feeding 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, gluten-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?

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

Child's name: _____ **Week of:** _____

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

