HEALTHY BEGINNINGS
PEDIATRIC THERAPY

Feeding Questionnaire

Today's date:_____ Pediatrician/primary medical care provider:

Child's name:_____ Name:_____

Date of birth:_____ Phone:_____

Sex (circle): Male or Female Date last seen:_____

Mother/Guardian:	Father/Guardian:
Date of birth:	Date of birth:
Address:	Address:
Phone: Carrier (i.e. Verizon)	Phone: Carrier (i.e. Verizon):
Email:	Email:
Employer (*name*):	Employer (*name*):
Address:	Address:
Phone:	Phone:

Child's Legal Guardian _____

Does your child have any medical diagnoses:

_____

What concerns do you have about your child's eating? Please check all that apply:

- ❑ Choking during a meal
- ❑ Food or liquid out of the nose
- ❑ Eats too much
- ❑ Difficulty swallowing
- ❑ Trouble breathing during feeds
- ❑ Fussing during feeds
- ❑ Other: _____
- ❑ Spits out food
- ❑ Slow weight gain
- ❑ Gagging/coughing
- ❑ Cries during meals
- ❑ Eats too little
- ❑ Refuses to eat by mouth
- ❑ Reflux during/after meals
- ❑ Vomits during/after meals
- ❑ Falling asleep during feeds
- ❑ Eats limited variety of food
- ❑ Refuses to swallow/holds in mouth
- ❑ Postural changes during feeds

Has problem changed? (circle) *Better or Worse*

When were you first aware that your child had feeding difficulties?

_____

Names of Medical Team Members (if applicable):

Does your child see (past or present) specialists/therapists to helping with feeding?

Dietician/nutritionist	**Physical Therapist**
Name: _____	Name: _____
Date seen: _____	Date seen: _____
Ear Nose and Throat	**Gastroenterologist**
Name: _____	Name: _____
Date seen: _____	Date seen: _____
Speech-Language Pathologist	**Early Intervention**
Name: _____	Name: _____
Date seen: _____	Date seen: _____

Occupational Therapist	**Other**
Name: _____	Name: _____
Date seen: _____	Date seen: _____

Medical History

Please note any of your child's medical, developmental and/or mental health concerns/diagnoses:

Frequently sick? (in general)	Past	Present (briefly describe)
Ear infections?	Past	Present (briefly describe)
Sinusitis?	Past	Present (briefly describe)
Diarrhea?	Past	Present (briefly describe)
Constipation?	Past	Present (briefly describe)
Bronchitis?	Past	Present (briefly describe)
Pneumonia?	Past	Present (briefly describe)
Cannot breathe through nose?	Past	Present (briefly describe)
Snoring or noisy breathing?	Past	Present (briefly describe)
Esophagitis?	Past	Present (briefly describe)
Neurologic (brain) issues?	Past	Present (briefly describe)
Renal(kidney) issues?	Past	Present (briefly describe)
Autism/PDD?	Past	Present (briefly describe)
Mental health issue? (specify)	Past	Present (briefly describe)
Genetic/chromosome abnormality?	Past	Present (briefly describe)
Failure to thrive/slow growth?	Past	Present (briefly describe)
Pulmonary (lung) issues (asthma)?	Past	Present (briefly describe)
Slow stomach emptying?	Past	Present (briefly describe)
Cardiac (heart) issues?	Past	Present (briefly describe)
Gastroesophageal reflux?	Past	Present (briefly describe)
Seizures?	Past	Present (briefly describe)
Surgeries?	Past	Present (briefly describe)

Have any of the following medical tests been done?

- ❑ Upper GI series
- ❑ Endoscopy
- ❑ Head CT scan
- ❑ Allergy testing
- ❑ Milk scan
- ❑ PH probe
- ❑ Head MRI scan
- ❑ Modified barium swallow study (or FEES testing)
- ❑ Bone age film/x-ray
- ❑ Genetic testing
- ❑ Other (specify) _____

Describe the child's sleep pattern: _____

Are you giving your child any medications, herbs or vitamins? If yes please list all supplements, herbs, medications, over the counter medications

Medication	**Dose**	**How often**

Is your child allergic to or does he/she react to the following?

- ❑ Prescription medications (reaction)_____
- ❑ Over the counter medications (reaction) _____
- ❑ Foods, food additives or drink (reactions) _____
- ❑ Latex or anything else such as bandages or tape (reactions)_____
- ❑ X-ray, CT, MRI, or other radiology dyes (reactions) _____
- ❑ Blood products (reaction)_____
- ❑ None known

Are your child's immunizations up to date? ❑ Yes ❑ No

Birth History

Was alcohol or any drug (including prescriptions) used before or during pregnancy? ___Yes (please describe) ___No

_____

Gestational Age at time of delivery (or # weeks early or late): _____

Length of Labor (in hours)? _____

Any type of labor stimulation and what was used? _____

Any type of pain medication or anesthesia used during delivery (name, type, amount if known)?
Pain relief Anti-vomiting
Sedation Anesthesia
What type of delivery (please circle)? Vaginal Cesarean Section (circle): elective, emergency
Presentation (circle): Head, Face, Breech, Transverse Reason for C-section _____
Assistance (circle): Forceps, Vacuum, other _____

Did you experience any problems during the labor/delivery? _____

What was the condition of your infant while in the nursery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc.):

NO	YES	DESCRIPTION	EXPLANATION
		Was blue/cyanotic at birth	
		Required stimulation to breathe	
		Required oxygen at birth	How much/what type?
		Required resuscitation	
		Was considered small for gestational age	
		Had tremoring or seizures	Which/for how long?
		Very low tone	
		Brain hemorrhage	
		Anemia and/or transfusions	Which/how many times?
		Jaundice (yellow)	How much/how treated?
		Had bruising	
		Rh incompatibility problems	
		Infections	
		Congenital birth defects	
		Aspiration (meconium or fluid)	Which/how treated?
		Respiratory distress signs or syndrome	
		Needed ventilation	What type/how long?
		Choking or vomiting episodes	
		Tube feedings	
		Needed medications	

Family and Social History

Child lives with (Check all that apply):

- ❑ Birth parents
- ❑ One parent
- ❑ Adoptive parents
- ❑ Foster parents
- ❑ Parent and step-Parent
- ❑ Other:_____

Family's primary language _____

Other children in the family:

Name Age Sex Any developmental concerns?

_____

_____

_____

Any family history of feeding, swallowing, or developmental concerns?

_____

Developmental History

We would like to have information about your child's developmental milestones. Please mark whether you believe your child accomplished the milestones early, on time or late. If your child has not yet achieved the milestone, check N/A.

MILESTONE	Early	On Time	Late	N/A
Gross motor milestones:				
• Rolled over (3-6 months)	❑	❑	❑	❑
• Sat unsupported (6-9 months)	❑	❑	❑	❑
• Crawled (9 months)	❑	❑	❑	❑
• Stood alone (10-12 months)	❑	❑	❑	❑
• Walk by self (18 months)	❑	❑	❑	❑
Fine motor milestones:				
• Transferred object between hands (6 months)	❑	❑	❑	❑
• Feeds self finger foods (8 months+)	❑	❑	❑	❑
• Helps with undressing (1 year)	❑	❑	❑	❑
• Snips with scissors (2 years)	❑	❑	❑	❑
• Pedals tricycle (2-3 years)	❑	❑	❑	❑
• Catches ball (2 years)	❑	❑	❑	❑
Cognitive:				
• Identifies some letters and letter sounds (3-4)	❑	❑	❑	❑
• Understands idea of counting (4 years)	❑	❑	❑	❑
• Potty training (1.5-3 years)	❑	❑	❑	❑
Speech/Language:				
• Coos, babble, vocal play (0-6 months)	❑	❑	❑	❑
• Points to objects (7-12 months)	❑	❑	❑	❑
• Use first words (12-18 months)	❑	❑	❑	❑
• Uses two words together (1-2 years)	❑	❑	❑	❑
• Follows 1-part directions, like "Roll the ball" or "Kiss the baby." (1-2 years)	❑	❑	❑	❑
• Follows 2-part directions, like "Get the spoon and put it on the table." (2-3 years)	❑	❑	❑	❑

Please check if your child has received any of the following:

❑ Hearing evaluation When: _____Where: _____Concerns? _____
❑ Vision evaluation When: _____Where: _____ Concerns? _____
❑ Occupational Therapy evaluation When: _____ Where: _____ Concerns? _____
❑ Speech/Language Evaluation When: _____Where: _____Concerns? _____
❑ Physical Therapy Evaluation When: _____Where: _____ Concerns? _____

School History

If your child is in preschool, elementary or high school please answer the following:

Name of school: _____

Does your child receive speech therapy services in the school setting? ❑ Yes ❑ No

Nutrition/Feeding/Swallowing History

Is your child allowed to eat by mouth?

_____

Is your child allowed to drink by mouth?

_____

How often does your child have a bowel movement? (daily, every other day, other) Constipation, hard stools, diarrhea, other?

_____

Was your child fed through a feeding tube? If yes, for how long?

_____

On average how long does it take the child to eat?

_____

How is the child usually positioned during feeding?

❑ Infant seat ❑ Child stands ❑ On caretakers lap
❑ Highchair ❑ Child wanders around ❑ Booster seat
❑ In front of TV ❑ Chair at table ❑ Held in caretaker's arms

Where in the house is your child fed?

- ❑ Kitchen
- ❑ Dining room
- ❑ Living room
- ❑ Walking around
- ❑ Other (please specify) _____

With whom does your child usually eat/drink?

- ❑ Alone
- ❑ With parents
- ❑ With siblings
- ❑ With peers
- ❑ With nurse

At what other locations does your child eat/drink?

- ❑ Daycare
- ❑ School
- ❑ Other relatives' home
- ❑ In the car

Who feeds your child? (check all that apply)

- ❑ Child feeds self
- ❑ Mother
- ❑ Father
- ❑ Teacher
- ❑ Sibling
- ❑ Daycare provider
- ❑ Grandparent
- ❑ Nurse
- ❑ Other (specify)_____

Please check your child's CURRENT ability to eat a variety of food texture (by mouth):

Texture	**Eats easily**	**Eats with difficulty**	**Refuses**	**Cannot eat**	**Never tried**
Baby food					
Pureed table food					
Dissolvables (puffs, veggie sticks, cherios etc.)					
Chopped table food (e.g. pancakes)					
Crunchy table food (e.g. apple, crackers)					
Difficult to chew table food (e.g. meat)					

What do your child drink and how much (by mouth)?

- ❑ Milk _____ounces per day Type of bottle:_____
- ❑ Water _____ounces per day
- ❑ Infant formula _____ounces per day Name of formula: _____
- ❑ Juice _____ounces per day
- ❑ Nutritional supplement _____ounces per day Name of supplement:_____
- ❑ Soda/tea _____ounces per day
- ❑ Thickened liquids _____ounces per day
- ❑ Other _____ounces per day

What foods does your child like to eat?

_____

What foods does your child *not* like to eat?

_____

Do you add anything extra such as butter, oil etc. to foods to increase calories? (circle) Yes No

If yes please specify what you add and how much:_____

How is your child positioned during feeding?_____

When is bottle/breast offered?_____

Is child spoon fed?	❑ Yes ❑ No	What type of spoon? _____	
Drinking from breast?	❑ Yes ❑ No		
Drinking from bottle?	❑ Yes ❑ No	What type of bottle?_____	
Straw drinking?	❑ Yes ❑ No		
Drinking from cup?	❑ Yes ❑ No	What type of cup? _____	
Does child feed him or herself?	❑ Yes ❑ No		
Finger feeding? (circle)	Beginning	Partially successful	Completely successful
Feeds self with spoon? (circle)	Beginning	Partially successful	Completely successful
Feeds self with fork? (circle)	Beginning	Partially successful	Completely successful

Please circle the words that describe your child's temperament or personality: (please circle all that apply)

Shy Outgoing Adaptable Flexible Strong-willed Active Quiet Distractible

Sensitive Easygoing Stubborn Rigid Anxious/Worrier Aggressive Attention problems

Temper tantrums Irritable/cranky Difficulty following directions

Does your child have any oral restrictions for solid food or liquids? (for example, no thin liquids-needs nectar-thick liquids, sensitive gag-needs purees working on increased texture.) _____

_____

Are there any foods you family avoids because of religious, social or cultural reasons? _____

_____

Does anyone in your family follow a special diet for medical reasons? _____

_____

How does your child let you know when he or she feels hungry? _____

_____

How does your child let you know when they feel full? _____

_____

Feeding Tube History (complete if applicable):

What type of feeding tube does your child currently use?	
When your child was first feeding tube placed? What kind of tube (NG, G or G-J)?	
What the primary reason (s) for the tube placement?	
What kind of formula or home blended diet do you currently use of tube feedings?	
Do you use a recipe? (if so, please describe	
Does your child have a daily goal for tube feeding amounts? (If so, please describe)	
What formulas have you used in the past?	
Schedule: (includes times, amount given and rates)	
Are there signs that your child is ready to transition to oral feeding? (please share with us why you think your child is ready for this.)	