Parent Feeding Questionnaire

Child's Name: _____

Date of Birth: _____

Address:

_____

_____

Parent/Guardian Names:_____

Home Phone:_____

Cell Phone:_____

E-Mail:_____

Referral Source:_____

History and Concerns About Eating/Drinking

What are the feeding concerns you have for your child?

What illness or surgical procedures has your child had (if any)?

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Is your child on medications? If yes, what are they?

What previous feeding assessments or studies has your child had?

Is a dietician working with your child? If yes, who and how often?

If your child receiving therapy? If yes, what kind and with whom?

Does your child attend a preschool or school program? If yes, where?

PRENATAL/BIRTH HISTORY

Full Term: Yes No
If no, how many weeks?

Birth Hospital:

Illnesses or accidents during pregnancy:

Birth weight:

Delivery: Vaginal Cesarean

Mother or Child remain in Hospital for any complications?

Other unusual conditions that may have affected pregnancy or birth?

Did your child experience Feeding/Sucking/Swallowing Issues at birth?

MEDICAL HISTORY

Are immunizations current?
Current general health:
**Has your child had any ear aches/ear infections? Y N Please explain here:

Allergies? (Describe)

Reflux?(Diagnosed by whom and when)

Any other serious or recurrent illnesses?

Other Medical History:

DEVELOPMENTAL HISTORY

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Age when child: (If you cannot remember specific time, please indicate if it occurred at the expected time or if it was delayed)
Sat up alone _____ crawled _____ walked _____ toilet trained_____
Fed self independently _____

Is the child left or right handed?

Able to use: open cup spoon straw

Any difficulty? (Y/N) Swallowing: Chewing: Drinking:

Blowing: Drooling: Tolerating a bath:

Tolerating dirty hands: Tolerating lotion on hands/body:

Tolerating loud noises or bright lights:

Feeding History

Describe your child's early feeding history:

- Breast-fed? How long? Problems?

- Bottle-fed? Problems?

What formula(s) was/is your baby on?

How does your baby tolerate formula?

What was the first food you introduced to your child and at what age? (puree, rice cereal, baby food)

How did your child do with the food?

How did your child do with the transition to lumpy and solid foods?

When did the feeding problem begin?

Current Feeding Routine

How often does your child eat and drink? What are his or her usual meal and snack times?

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What food/liquids does your child usually eat for:

Breakfast:

Lunch:

Dinner:

Snacks:

How is the food prepared? (Check all that apply)

- o Regular Liquid
- o Thick Liquid
- o Commercial pureed baby food: What brand? _____
- o Prepared in the blender

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- o Ground or commercial foods
- o Mashed soft table foods
- o Regular table food (soft)
- o Regular table food (hard)
- o Other (Please specify)

Which of these types of foods are easiest for your child?

Which of these types of foods are hardest for your child?

What do you usually use when feeding your child (Check all that apply.)

- o Breast
- o Fork
- o Bottle
- o Fingers
- o Cup: what type of cup_____
- o Straw
- o Spoon

Which of the following can your child use independently?

- o Fork
- o Fingers
- o Spoon
- o Cup
- o Bottle
- o Straw

Does your child have favorite food tastes? What are they?

Does your child have favorite food textures? What are they?

Does your child prefer food at a certain temperature (e.g., cold, warm, hot, room temperature)?

Is your child averse or resistant to any foods? If so which foods and what is his/her reaction to food?

Who usually feeds your child?

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Who else can feed your child?

Where is your child fed (e.g., in a chair, on your lap)

How long does it take to feed your child?

What is the average amount of food and liquid your child takes during that time?

Does your child have any food allergies that you are aware of?

Do any other family members have allergies (e.g., food, chemicals, pollens, molds)?

Does your child have problems with:

Gagging? (Please describe)

Gastroesophageal Reflux? (Please describe)

Vomiting? (Please describe)

Constipation? (Please describe)

Other Comments:

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