

FEEDING QUESTIONNAIRE - Solo

FEEDING QUESTIONNAIRE

1. Client information:

Client's First Name:

Client's Last Name:

Date of Birth:

Your Preferred Service Location:

209 Cherry St, Milford, CT

29 Federal Rd. Danbury, CT

ORAL/FEEDING HABITS AND SENSORY INFORMATION

2. Do you or your child's pediatrician have any concerns with their weight gain/ nutritional intake?

Yes

No

Please explain:

3. Did your child have any difficulties nursing or bottle feeding (i.e. crying, gagging, difficulty latching on)?

Yes

No

Please explain:

4. At what age did you introduce spoon feeding?

5. Did your child have any difficulty with pureed foods?

Yes

No

Please explain:

6. At what age did you introduce solid foods (i.e. Cheerios)?

7. Does your child exhibit open mouth posture and/or mouth breathe?

- Yes
- No

If so, please explain.

8. Is your child sensitive to textures?

- Yes
- No

If so, please explain.

9. Is your child sensitive to sounds?

- Yes
- No

If so, please explain.

10. Is your child sensitive to smell?

- Yes
- No

If so, please explain.

11. How is your child's sleeping patterns?

12. Does your child have any food aversions?

- Yes
- No

If so, please explain.

13. Please describe any food aversions you child might have to the following:

	Please explain
Taste (i.e. sweet, salty, spicy)	
Texture (pureed,soft solids,chewy,crunchy)	
Temperature (warm,cold,room temperature)	
Color	
Size/Shape	

14. Please describe any unusual food preferences your child might have:

15. Is your child on a restrictive diet (Gluten Free, etc.)?

- Yes
- No

If so, please explain.

16. Does your child have any difficulties with the following eating skills? (please check all that apply)

- cup drinking
- straw drinking
- eating with a fork
- eating with a spoon
- tires easily during meals
- swallowing
- forming a bolus
- eating with fingers

17. Does your child display any of the following behaviors during eating? (please check all that apply)

- choking
- gagging
- drooling
- crying
- nausea
- gurgly voice
- vomiting
- constipation
- diarrhea

18. Do you think your child's eating habits are linked with behaviors displayed?

- Yes
- No

Please explain.

19. When did you notice your child's feeding difficulties?

20. What consistency of foods does your child tend to eat most?

- | | | |
|---|--|--|
| <input type="checkbox"/> regular liquids | <input type="checkbox"/> thickened liquids | <input type="checkbox"/> baby cereal |
| <input type="checkbox"/> chewy | <input type="checkbox"/> smooth solids | <input type="checkbox"/> semi-chunky |
| <input type="checkbox"/> chunky | <input type="checkbox"/> sour/intense flavor | <input type="checkbox"/> mashed table food |
| <input type="checkbox"/> regular table food | <input type="checkbox"/> crunchy | <input type="checkbox"/> soft foods |

21. At what temperature does your child desire the food? (check all that apply)

- | | | |
|------------------------------|-------------------------------|---|
| <input type="checkbox"/> hot | <input type="checkbox"/> cold | <input type="checkbox"/> room temperature |
|------------------------------|-------------------------------|---|

**22. Does/did your child display any of the following habits/problems or have they in the past?
Please check all that apply.**

- | | | |
|---|--|--|
| <input type="checkbox"/> Difficulty chewing food | <input type="checkbox"/> Holds food in mouth or cheeks | <input type="checkbox"/> Spitting food out of mouth |
| <input type="checkbox"/> Throwing food | <input type="checkbox"/> Tantrums while eating | <input type="checkbox"/> Chewing on non-food objects |
| <input type="checkbox"/> Mouthing on non-food objects | <input type="checkbox"/> Aversion to smells | <input type="checkbox"/> Taking medication |
| <input type="checkbox"/> Eating foods in certain environments | <input type="checkbox"/> Unwilling to try new foods | |

23. List any other difficulties:

FEEDING ENVIRONMENT

24. Where does your child eat during feeding times?

25. Is your child given a choice of what foods he/she can eat?

- Yes
- No

If so, please explain.

26. Are feeding times at the same times each day?

- Yes
- No

Please explain:

27. At which feeding time/meal does your child consume the most?

28. Are there any other activities (i.e.- TV/music/distractions) going on during feeding time?

- Yes
- No

If so, please explain.

29. What other individuals are in the area during feeding times? Is this consistent during all feeding times?

- Yes
- No

If so, please explain.

30. How long does a typical meal last with your child?

31. Please list the name brand of your child's utensils, cups, straws, and/or bottles that are being used at this time:

FEEDING RECORD (BASELINE DIET)

32. Please take the time to record all food items that have been eaten over the course of five days. This information can give the therapist an idea of typical foods consumed by your child.

	Day 1	Day 2	Day 3	Day 4	Day 5
Breakfast					
Lunch					
Dinner					
Snacks					

33. Please check the following difficulties your child is having now.

- Will not eat enough
- Refuses to eat certain textures/foods
- Has difficulty drinking liquids
- Has difficulty with solid foods
- Has difficulty with temperatures of foods (i.e., likes food only cold/hot)

FOOD INVENTORY

Instructions: Check off any food that your child would easily accept to eat if it was served at the specified mealtime. Several items are listed under lunch and supper. Only check off the items in both places if your child would be served these foods at both meals. For example, if your child would eat peaches at lunch but it would not be served a part of supper, then check off peaches only under lunch. The "Seasonings and Condiments" section describes flavors your child would eat at any meal.

34. Breakfast

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> cereal, cold | <input type="checkbox"/> cereal, hot | <input type="checkbox"/> milk |
| <input type="checkbox"/> juice | <input type="checkbox"/> water | <input type="checkbox"/> breakfast drink |
| <input type="checkbox"/> English muffin | <input type="checkbox"/> bagels | <input type="checkbox"/> muffins |
| <input type="checkbox"/> Danish, donuts | <input type="checkbox"/> cream cheese | <input type="checkbox"/> jam |
| <input type="checkbox"/> jelly | <input type="checkbox"/> eggs | <input type="checkbox"/> bacon |
| <input type="checkbox"/> sausage | <input type="checkbox"/> ham | <input type="checkbox"/> toast |
| <input type="checkbox"/> home fries | <input type="checkbox"/> Ketchup | <input type="checkbox"/> pancakes |
| <input type="checkbox"/> waffles | <input type="checkbox"/> French toast | |

35. List specific types of foods for items checked above (e.g., oatmeal, cheerios, apple juice, strawberry milk).

36. List specific brands if your child will eat one kind of a specific food.

37. List specific types of foods for items checked above (e.g., ham sandwich, saltines, chicken soup).

38. List specific brands if your child will eat only one kind of a specific food.

39. List any items your child prefers that are not listed above.

40. Dinner

- | | | |
|--|--|---|
| <input type="checkbox"/> steak | <input type="checkbox"/> roast beef | <input type="checkbox"/> pork roast |
| <input type="checkbox"/> lamb | <input type="checkbox"/> hotdogs | <input type="checkbox"/> hamburgers |
| <input type="checkbox"/> ground beef | <input type="checkbox"/> chicken nuggets | <input type="checkbox"/> chicken |
| <input type="checkbox"/> fish | <input type="checkbox"/> nachos | <input type="checkbox"/> soup, stews |
| <input type="checkbox"/> pasta w/ butter | <input type="checkbox"/> pasta w/ cheese | <input type="checkbox"/> pasta w/ tom sauce |
| <input type="checkbox"/> lasagna | <input type="checkbox"/> rice | <input type="checkbox"/> couscous |
| <input type="checkbox"/> beans | <input type="checkbox"/> French fries | <input type="checkbox"/> mashed potatoes |
| <input type="checkbox"/> baked potatoes | <input type="checkbox"/> tater tots | <input type="checkbox"/> cheese |
| <input type="checkbox"/> cottage cheese | <input type="checkbox"/> carrots | <input type="checkbox"/> celery |
| <input type="checkbox"/> lettuce | <input type="checkbox"/> tomato | <input type="checkbox"/> green beans |
| <input type="checkbox"/> sweet peppers | <input type="checkbox"/> mushrooms | <input type="checkbox"/> spinach |
| <input type="checkbox"/> peas | <input type="checkbox"/> summer squash | <input type="checkbox"/> winter squash |
| <input type="checkbox"/> applesauce | <input type="checkbox"/> fruit cocktail | <input type="checkbox"/> peaches |
| <input type="checkbox"/> banana | <input type="checkbox"/> juice | <input type="checkbox"/> milk |
| <input type="checkbox"/> soda | <input type="checkbox"/> water | <input type="checkbox"/> cake |
| <input type="checkbox"/> pie | <input type="checkbox"/> pudding | <input type="checkbox"/> jello |
| <input type="checkbox"/> yogurt | <input type="checkbox"/> cookies | <input type="checkbox"/> ice cream |

41. List specific types of foods for items checked above (e.g., brown rice, swordfish, pepperoni pizza, Coca-Cola).

42. List specific brands if your child will eat only one kind of a specific food.

43. List any items your child prefers that are not listed above.

44. Snacks

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> corn chips | <input type="checkbox"/> potato chips | <input type="checkbox"/> pretzels |
| <input type="checkbox"/> crackers | <input type="checkbox"/> nuts | <input type="checkbox"/> popcorn |
| <input type="checkbox"/> fresh fruit | <input type="checkbox"/> fruit rollups | <input type="checkbox"/> fresh vegetables |
| <input type="checkbox"/> chocolate | <input type="checkbox"/> yogurt | <input type="checkbox"/> cheese |
| <input type="checkbox"/> ice cream | <input type="checkbox"/> sour candy | <input type="checkbox"/> sweet candy |
| <input type="checkbox"/> milk | <input type="checkbox"/> juice | <input type="checkbox"/> soda |

45. List specific types of foods for items checked above (e.g., tortilla chips, goldfish, fudgesicle, etc.).

46. List specific brands if your child will eat only one kind of a specific food.

47. List any items your child prefers that are not listed above.

48. Seasonings and Condiments

- | | | |
|---|---|---|
| <input type="checkbox"/> ketchup | <input type="checkbox"/> spicy mustard | <input type="checkbox"/> soy sauce |
| <input type="checkbox"/> barbecue sauce | <input type="checkbox"/> salsa | <input type="checkbox"/> Worcestershire |
| <input type="checkbox"/> relish | <input type="checkbox"/> lemon juice | <input type="checkbox"/> lime juice |
| <input type="checkbox"/> vinegar | <input type="checkbox"/> salad dressing | <input type="checkbox"/> mayonnaise |
| <input type="checkbox"/> olives | <input type="checkbox"/> pickles | <input type="checkbox"/> parsley |
| <input type="checkbox"/> oregano | <input type="checkbox"/> paprika | <input type="checkbox"/> basil |
| <input type="checkbox"/> curry | <input type="checkbox"/> ginger | <input type="checkbox"/> cinnamon |
| <input type="checkbox"/> onion | <input type="checkbox"/> garlic | <input type="checkbox"/> black pepper |
| <input type="checkbox"/> hot pepper | <input type="checkbox"/> horseradish | <input type="checkbox"/> salt |
| <input type="checkbox"/> yellow mustard | | |

49. Others:
