CHILD'S NAME:	DATE OF BIRTH:
TODAY'S DATE:	COMPLETED BY:

CONCERNS:

1. How would you describe your child's eating/swallowing problem?

_____

2. When did you first become concerned? _____

   Has there been improvement in this area? ☐ Yes ☐ No

3. Describe any evaluations that you have completed for this problem:

_____

_____

FEEDING HISTORY

1. How was your child fed as an infant? ☐ Bottle ☐ Breast ☐ Nasogastric Tube ☐ Gastric Tube ☐ Other _____

2. Describe any problems your child had or continues to have: _____

_____

3. Complete all those that apply:

	Age Introduced	Age Mastered	Describe Difficulties
Bottle feeding			
Cereal			
Pureed foods – stage 1			
Pureed foods – stage 2			
Pureed foods – stage 3			

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FEEDING QUESTIONNAIRE PEDIATRIC THERAPIES

911404

Patient Name: _____
MR Number: _____
Patient Number: _____
OR
Affix Patient Label

	Age Introduced	Age Mastered	Describe Difficulties
Mashed table foods			
Chopped table foods			
Bite-sized finger foods			
Teething biscuits			
Cookies/crackers			
Partial table foods			
Full table foods			
Sippy cup			
Open cup – assisted			
Open cup – independent			
Straw			

4. Describe any other problems that your child had/has in any of the above areas: _____

_____

_____

_____

5. Describe anything that you thought improved these problem areas: _____

_____

_____

_____

_____

CURRENT FEEDING SKILLS

1. Describe your child's feeding schedule. Include all meals and snacks: _____

_____

_____

_____

2. Do meals occur as a structured activity with the entire family? ☐ Yes ☐ No

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FEEDING QUESTIONNAIRE PEDIATRIC THERAPIES

911404

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3. Who usually initiates a meal? _____; a snack? _____

   Who usually ends a meal? _____; a snack? _____

   Describe: _____

   _____

4. Who usually feeds your child? (check all that apply) Rank in order of most often (1) to least often (7).

   ☐ Mother ☐ Father ☐ Grandparent ☐ Sitter
   ☐ Sibling ☐ Feeds Self ☐ Other

5. Does your child feed/eat better for some feeders? ☐ Yes ☐ No
   Describe: _____

   _____

6. How is your child usually positioned during feedings? Note if positioning is different for solids and liquids. (check all that apply).

	Solids	Liquids
☐ Lying down	_____	_____
☐ Held on your lap	_____	_____
☐ Infant Seats	_____	_____
☐ High Chair	_____	_____
☐ Sassy Seat	_____	_____
☐ Booster Seat	_____	_____
☐ Sitting in a wheelchair	_____	_____
☐ Sitting in a chair at the table	_____	_____

   ☐ Other (explain): _____

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

   ☐ Regular liquid
   ☐ Thick liquid (consistency: _____)
   ☐ Commercial strained baby food
   ☐ Blenderized (pureed) food
   ☐ Commercial junior baby foods or third foods
   ☐ Other _____

   ☐ Table foods - ☐ Ground
   ☐ Fork mashed
   ☐ Chopped fine
   ☐ Soft
   ☐ Regular

8. What "utensils" are usually used during feeding? (Check all that apply.)

   ☐ Bottle
   ☐ Sippy Cup (lid or spout)
   ☐ Cup (no lid)/Glass
   ☐ Straw
   ☐ Other: _____

   ☐ Spoon
   ☐ Fork
   ☐ Fingers
   ☐ Gastric tube

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FEEDING QUESTIONNAIRE PEDIATRIC THERAPIES

911404

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9. How long does it usually take your child to eat?

☐ 5-10 minutes ☐ 15-20 minutes ☐ 30 minutes
☐ Longer than 30 minutes (How long? _____)

10. How do you know that your child is hungry? _____

_____

11. How do you know that your child is full? _____

_____

12. Has your child had any of the following:

	Frequently	Sometimes	Never
Pneumonia or other respiratory problems			
Gurgly sounds before, during, or after feedings			
Coughing, choking, or gagging with liquids			
Coughing, choking, or gagging with food			
Difficulty chewing			
Pocketing foods			
Spitting out foods			
Spitting up			
Vomiting			
Arching/increased tone during meals			
Crying/irritability before, during or following meals			
Resisting or refusing feedings			
Constipation			
Diarrhea			
Difficulty going to sleep			
Waking in night			
Food allergies			

13. Medications: _____

14. Describe any other feeding comments / concerns / behaviors: _____

_____

_____

Date _____Time _____ Signature _____Relationship_____

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