The Children's Therapy Center

# Feeding Questionnaire

****** Please bring 3 preferred and 3 non-preferred foods with your child to the evaluation ******

Child's Name: _____

Child's DOB:_____Person Completing Form:_____

1. What is the current method of feeding?
   _____NPO _____PO _____NG tube _____G tube _____GJ tube

2. Was your child successful with a bottle? _____Yes _____No

   Problems observed:_____

3. When did your child begin solids? (cereal, Baby food) _____

   Did your child progress through solids? _____Yes _____No
   Check all that apply below:
   ___Baby cereal____Stage 1_____Stage 2 _ Stage 3_____Purees ___Soft chewables_____Hard chewables

4. Does your child drink a variety of liquids? _____Yes _____No

   Which ones:_____

   When?____before ___during ___after meals

   Via:_____bottle_____sippy cup_____drink box_____open cup _straw

5. Is your child able to self-feed? _____Yes _____No

   With:____fork_____spoon_____finger feed

6. What is your child's arousal level during feeding?
   ___deep sleep_____light sleep_____drowsy_____quiet/alert_____active/alert_____crying Other: _____

7. What behaviors does your child exhibit during feeding? _____
   _____

8. Feeding schedule:
   Breakfast: Time:_____
   Foods: please list:_____

   Lunch: Time:_____
   Foods: please list:_____

   Dinner: Time:_____
   Foods: please list:_____

   Snacks: Time:_____
   Foods: please list:_____

9. Does your child receive supplemental feeding?_____Yes _____No

   If yes, describe:_____

10. How long is each meal? _____

11. Describe the environment where your child usually eats (such as room, type of chair, music/tv on).

    _____

12. Does your child eat **more/less** (circle one) foods in different environments, in school, outside events, etc?
    Does your child eat **same/different** (circle one) foods in different environments?
    Please describe: _____

13. Please list your child's favorite foods to eat? _____

    _____

14. Please list any foods that your child refuses? _____

    _____

    If different from your child's refused foods, please list foods that are difficult for your child to eat? _____

    _____

15. Is there a texture/consistency that your child prefers?
    ___puree____lumpy____crunchy____liquids____chewy____other: _____

16. Is there a texture/consistency that your child dislikes or refuses?
    ___puree____lumpy____crunchy____liquids____chewy____other: _____

17. Please list any evaluations and or treatments if you have previously tried to help your children with his/her problem: _____

    _____

18. Please describe any other comments about your child's feeding: _____

    _____

19. What are your goals for your child in regards to their feeding? _____

    _____

    _____

**Please bring this questionnaire completed along with other suggested items to the initial feeding evaluation. We appreciate your time and participation in helping us provide a thorough feeding evaluation for your child.**

**Suggested items:**

- **Previous feeding evaluation reports (ie swallow studies)**
- **GI evaluations**
- **Any special seating equipment for feeding time**
- **Typical utensils used for feeding (bottle, cup, fork, plate, etc)**
- **Unsuccessful or refused food items**
- **Preferred food items**
- **Variety of textured foods—purees (baby foods, applesauce, pudding, etc.)**
  **Soft chewables (cooked vegetables, etc)**
  **Hard/crunchy chewables (cereal, crackers, chips, etc)**