Developmental Therapy Associates
& Absolute Speech and Language Therapy

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FEEDING QUESTIONNAIRE

Child's Name: _____ Date of birth: _____

Which of the following issues would you liked addressed? (Choose all that apply):

- Decrease coughing/choking ☐
- Improve eating skills (puree/chewing) ☐
- Increase variety of foods my child eats safely ☐
- Increase the volume of food consumed ☐
- Decrease gag/vomit related eating ☐
- Congestion during eating ☐
- Reflux or other GI issues ☐
- Improve cup drinking ☐
- Improve mealtime behaviors ☐
- Constipation ☐
- Decrease tube feedings ☐
- Oral residue or pocketing ☐
- Holding food in mouth ☐
- Mouth stuffing ☐
- Eliminate bottle ☐
- Fear of eating ☐
- Weight gain ☐
- Picky eating ☐

Reduce mealtime stress ☐ Feeding milestones ☐

Other

Was your child breastfed? Yes How long was you child breastfed:

Was your child bottle-fed: Yes

Please describe your child's initial skill on the breast and/or bottle:

During these early feedings, did your child (mark all that apply):

Arch ☐ Cough ☐

Gag ☐ Vomit ☐

Cry ☐ Pull away from nipple ☐

Spit up ☐

Describe how the weaning process off the breast and/or bottle went and why the child was weaned:

At what age was child introduced to:

Baby Cereal N/A Finger Food 5 months

Baby Food 11 months Table Food 5 months

When did your child transition fully to table food (if applicable) ex: 23 months old:

Please describe how these transitions were handled by your child, especially if any difficulties occured:

Please list items your child currently will eat and drink, if any, in the following categories with favorites listed first:

Liquids:

Dairy:

Fruits:

Vegetables:

Grains:

Meats:

Please list any food that your child refuses to eat (if any)

Please list the foods your child is allergic to (if any)

Who typically feeds your child?

Does your child eat with the family? No

Does your child sit at the table for meal time? No If yes, for how long?

Who typically eats with your child?

What type of chair is used? Table Chair

What type of utensils, bowl, cup, and plate does your child use (describe):

Will your child allow new foods near them? Sometimes Will they touch new foods? Sometimes

Will they place new foods in their mouth? Sometimes

IF YOUR CHILD IS TUBE FED, PLEASE ANSWER THE FOLLOWING QUESTIONS, OTHERWISE SKIP TO NEXT SECTION:

What type of formula is used and exactly how do you mix it?

Please describe where your child is tube fed and what activities are occurring at the same time.

Please describe your child's reaction to the tube feedings (e.g., upon connection, during feeding, during disconnection

PLEASE ANSWER FOR ALL CHILDREN

Has your child ever been on a special diet? No

If yes, please explain:

How do you know when your child is hungry?

How do you know your child is full?

Has your child lost or gained any weight in the last 6 months? Yes - Gained

If yes, how much?

How would you describe your child's weight? Underweight

Does your child currently have or previously had any of the following:

Dental Yes

Frequent constipation Yes

Frequent diarrhea Yes

Vomiting Yes

Choking Yes

Gagging Yes

Coughing Yes

Has your child had any previous swallow studies or feeding therapy? Yes

If yes, with who, for how long, and results

Has your child been referred for gastrointestinal testing? If so please describe the results and any medication prescribed.

Please describe your child 's bowel movements. Runny

Frequency of bowel movements: 1-2x daily

Does your child snore or breathe with an open mouth? Sometimes

Does your child take a vitamin supplement? No If yes, which one

Please describe how you feel after a feeding.

Please describe hour your child feels after a feeding.

What (if any) other evaluations have been completed regarding your child's feeding difficulties, and what were the results?

What treatments have been tried for your child's feeding difficulties, and what were the results?

How can DTA be most helpful to you and your child?