Pediatric Feeding Questionnaire

Intro Questions

What Concerns do you have about your child's eating?

- Oral-motor, sucking or chewing ability?
- Nutrition: weight gain, food allergy or intolerance?
- GI: gagging, vomiting, constipation?
- Swallowing- aspiration, coughing or choking?
- Other:

What are your goals for feeding?

At what age was your child when eating first became a concern?

Has your child been seen by any other specialist/therapist to help with feeding?
If so, whom has your child seen?
What has been tried to improve feeding?

Are you concerned about your child's weight?

In the last 6 months, were there times when to was not possible to feed your family a healthy meal (including formula) because there was no enough money?

Birth History

Were there any complications during pregnancy ?

Gestation age:

Birth weight:

Were there any complications with your child at birth ?

Was the baby in the NICU? If yes, how long?

Feeding History

Was your baby breast fed? If yes, for how long? If yes, did your baby have any difficulty breast feeding?

Did your baby ever drink from a bottle? If yes, did your baby have any difficulty bottle feeding?

Did your baby ever drink formula? If yes, what brands of formula?

At what age did you start start spoon feeding puree? Any difficulty?

At what age did you start solids/table foods? Any difficulty?

At what age did your child start drinking from a cup? Any difficulty?

Eating Environment

Where does your child usually eat?

- infant seat, high chair, booster seat, chair at able, child stands, child wanders around, held, other

What location does your child eat/drink?
- Home, daycare, school, relatives/others homes, in car

Who feeds your child?
- Mother, Father, sibling, Grandparent, teacher/aide/daycare provider, other

Child currently spoon fed?

Child currently feeds self?

Child currently drinks from a bottle?

Child currently drinks from a cup? If yes, what type of cup

Child currently drinks from a straw?
What textures does your child accept easily?
- Store bought baby food, homemade puree, dissolvable solids, soft table foods, crunchy table foods, difficult to chew food

Intake: What does your child eat and drinks and how much?

Drinks	Amount/cups/day	utensil (bottle, cup, straw)	Other
Milk			
Formula/ supplements			
Water			
Juice			
Soda			
Tea			
Other			

Food group: please give examples of foods you child will eat.

Food Group	Eaten Easily	Sometimes Eaten	Used to eat
Fruit			
Vegetables			
Grains			
Proteins (meats, egg, peanut butter)			
Dairy: (milk, cheese, yogurt) or alternative (soy, almond milk)			

Daily Intake: please provide a 3 day history of what your child eats and drinks in a day. (Include food, liquids and amounts taken in)

Meals	Day 1	Day 2	Day3
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Nighttime eating or drinking			

Do you add anything such as butter, oil, cream to increase calories?

Does your child receive tube feedings? If yes, When did your child first start feeding through a tube? Type of tube used? OG, NG, G., GJ

What is your child's tube feeding schedule?

Medical Questions

Does your child have asthma or any difficulty breathing?

Does you child have allergies? If yes, to what?

How often does you child have a bowel movement ?
(circle on Bristol Stool chart)

Does your child have constipation?
    If yes, does your child take medicine for this?

Have any of the following medical tests been completed?

- Labs, Upper GI Series, Gastric Emptying Scan, Modified Barium Swallow Study., Endoscopy, Bronchoscopy, Laryngoscopy, pH probe, Genetic testing, Head CT or MRI
- Any other medical tests?

Does your child gag with eating?

Does your child vomit with eating?

Does your child have gastroesophageal reflux?

Does your child take any medicines?
    If yes, please list medicines, dose, and time given.