1515 Johnson Ferry Road
Suite 100
Marietta, Georgia 30062
Phone: (770) 977-9457
Fax: (770) 977-5087

Greater Atlanta Speech and Language Clinics

Working Together for a Greater Tomorrow

Mindy C. Elkan, M.A., CCC
Clinical Director
Michelle Needle, M.Ed.,CCC
Assistant Director

CONFIDENTIAL FEEDING QUESTIONNAIRE FOR EVALUATION

(All information provided is strictly confidential and will not be provided to any other agency without your written consent.)

Child's Name: _____ Evaluation Date: _____

Child's Age: _____ Date of Birth: _____

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

I. GENERAL INFORMATION

Primary Reason for Referral (Please circle all that apply)

a. My child is feeding tube dependent and accepts little food by mouth

b. My child mostly get nutrition by drinking formula

c. My child has lost weight (_____ pounds)

d. My child only eats certain food/ is extremely picky

e. My child has poor self-feeding skills

f. My child eats too much or is gaining weight

g. Other: _____

Describe what concerns you have about your child's eating: _____

_____

When did you first notice this problem? _____

List any diagnoses your child has and the professional who made the diagnosis (include dates):

_____ _____

_____ _____

Has your child received any previous treatment for this specific problem? ____ yes _____no

If yes, where/when: _____

_____

Is a second language spoken in the home? _____ Is so, what language? _____

Please list other persons living in your home, their ages, and relationship to child:

_____

_____

What do you hope to learn from this evaluation and what specific questions do you have or areas do you wish to address? _____

_____

II. MEDICAL INFORMATION:

Current Height: _____ Current Weight: _____

Has a medical provider ever expressed concerns regarding your child's weight and growth? ___ Yes ___ No

If yes, please explain _____

Pregnancy:

Pregnancy Term: ___ Preemie: _____ weeks ___Full-term

Pregnancy Complications: ___None ___Gestational Diabetes ___Anoxia ___Pre-eclampsia

Other Complications: _____

Weight of child at birth: _____ pounds, _____ounce

Was there anything unusual in the baby's condition at birth or soon after, such as:

____ Injury ___ Paralysis ____ Cord wrapped around neck _____Bruises

____ Coloring (blue or yellow) ____ Other (explain): _____

Was the baby given blood transfusions or exchanges at birth? _____

Was the baby given oxygen? _____

Were there any problems after birth? _____ Such as: ____ Feeding problems _____ Seizures _____

During infancy, was child fed by bottle ____, breast ____, combination _____

At what age were solids introduced? _____

III. HEALTH HISTORY

1. Check any illnesses the child has had. Specify information, such as age, degree of temperature, medical treatment received:

_____Measles	_____ Meningitis
_____ Whooping Cough	_____ Poliomyelitis
_____Scarlet Fever	_____ Encephalitis
_____ Influenza	_____ Epilepsy
_____Chicken Pox	_____Convulsions/ Seizures
_____Mumps	_____Falls or blows to the head
_____Tonsillitis	_____Frequent Ear Infections
_____Allergy	_____Frequent Colds
_____Pneumonia	_____Bronchitis
_____Asthma	_____Cardiac Issues
_____Constipation	_____Urinary Tract Infections
_____Other	

2. If you child has had more than one ear infection, how old was the child when the ear infections occurred?

_____

3. How were the ear infections treated (antibiotics, tube, etc.)? _____

4. Check any surgery your child has had. Specify date of surgery, where, duration of hospitalization, and attending physician:

_____ Tonsillectomy _____

_____ Adenoidectomy _____

_____ Ear Surgery, any type _____

_____Orthopedic Surgery, any type _____

_____Cardiac Surgery, any type _____

_____ Other _____

3. Is the child presently on medication? _____ If so, specify by name and reason prescribed:

_____

4. Does any member of the family have similar problems that the child has? _____

If yes, describe who and what the problem was_____

_____

5. Is child allergic to food, drink, insect bites, etc: _____ Explain: _____

_____

At what age did your child:

___	Lift head while on stomach	___	Drink from a straw
___	Roll over front to back	___	Drink from a cup without help
___	Sit alone	___	Use a spoon
___	Crawl on all fours	___	Stop wearing diapers during the day
___	Stand alone	___	Pedal a tricycle
___	Walk holding on to the furniture	___	Ride a bike
___	Walked independently	___	Walk down stairs unassisted
___	Give up a bottle during the night		

IV. Bowel Habits:

Frequency of Bowel Movements: _____ times per (circle one): day week

Consistency: hard soft loose watery

Is your child toilet trained? ____ Yes ____ No

Are there any concerns with toileting? ____ No ____ Yes _____

V. HOW DOES YOUR CHILD EAT/DRINK NOW?

1. Is your child currently allowed to eat by mouth? Yes No

2. Is your child currently allowed to drink by mouth? Yes No

Current Feeding Skills (check all that apply)

_____drinks from bottle _____held by caregiver _____child holds bottle

_____feeds self with fingers _____feeds self with spoon _____with help _____without help

_____feeds self with fork _____with help _____without help

_____drinks from open cup/glass _____with help _____without help

Describe any special diet that you adhere to for your child (Kosher, gluten-free, etc.)

_____

_____

Please indicate your child's typical mealtime schedule and sample meals. Give approximate amounts.

	Sample/Typical meal and how much offered	Amount child actually eats
Breakfast		
AM Snack		
Lunch		
PM Snack		
Dinner		
Other:		

Describe the sequence in which food is offered to your child (e.g., liquids always first, etc.):

_____

Does your child's food habits and preferences match the family's? Yes No

Does your child eat little meals and snacks throughout the day? Yes No

Your child's appetite is best described as (circle one): poor fair good excellent

How long does it take for your child to complete a meal? (circle one)

less than 10 minutes 10-20 minutes 20-30 minutes over 60 minutes

How does your child show hunger? _____

Do any foods cause physical problems when eaten? __ No __ Yes (Please

Explain)_____

Does your child have any food allergies ___ No ____ Yes (please list)

_____

Food Textures

Please check (√) your child's current ability to eat a variety of food textures:

Texture	Eats easily	Eats with difficulty	Refuses	Cannot eat	Never tried
Baby food					
Pureed table food					
Mashed table food					
Dissolvables (e.g. puffs, veggie sticks, cheerios)					
Chopped table food					
Soft table food (e.g. pancakes)					
Crunch table food (e.g. crackers, apple)					
Difficult to chew table food (e.g. meat)					

Please give examples of food your child will eat from all food groups

Food Group	**Examples**
Fruit	
Vegetables	
Protein (meats/eggs)	
Dairy (milk/cheese/yogurt)	
Grains (bread/cereal/pasta/rice)	

My child has the following behaviors that are problems at meals:

	Head turning		Aggression
	Pushing away the spoon		Does not remain sitting
	Screaming/Crying		Leaving the table
	Throwing food		Gagging/Vomiting
	Making negative statements		Holds food in mouth/refuses to swallow
	Eats a limited variety of food/selective		Refuses to eat
	Eats a limited volume of food		Other:

What strategies have you tried to deal with your child's eating problems?

___distraction during meals (e.g. games, TV)
___skipping meals
___rewards/punishments
___feeding child when s/he requests food ___coaxing
____ Other _____

___preferred foods
___forcing foods
___high calorie supplements/formula

VI. Oral Motor:

Check any of these **problems** that occur for your child:

	Drooling		Poor sucking
	Tongue Control (tongue thrust, poor mobility)		Lip Control (keeping mouth closed)
	Swallowing		Pocketing food (holding food in cheeks/mouth)
	Chewing (for children over 1 year)		Overstuffing (too much in mouth at one time)
	Hypersensitivity to textures, temperatures, spoon		Teeth grinding
	Aspiration		Coughing
	Other:		

VII. ADDITIONAL PARENT COMMENTS

Please provide your personal observations relative to the child's speech/language/hearing, motor skills, and/or behavior:

_____

_____

_____

_____

Completed by: _____ Relationship to client: _____
Signature

Date: _____