



**2018 PARENT/CAREGIVER QUESTIONNAIRE + FEEDING**

Date: \_\_\_\_\_

**GENERAL INFORMATION**

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_ Level of Education: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_ Level of Education: \_\_\_\_\_

**PATIENT HISTORY**

Why is your child here today?

\_\_\_\_\_  
\_\_\_\_\_

When was the problem first noticed? \_\_\_\_\_

Is your child aware of the problem?            Yes            No

If yes, how does your child feel about it? \_\_\_\_\_

How would you describe your child? \_\_\_\_\_

**FAMILY INFORMATION**

List all people in household:

Name	Age	Sex	Grade	Relation

Does anyone else in the family have speech, language, or hearing problems?

Yes            No

If yes, please describe: \_\_\_\_\_

What language(s) does your child speak? \_\_\_\_\_

**HEALTH & MEDICAL HISTORY**

Has your child ever been examined by any other professionals? Yes No

	Doctor	Practice	Date	Diagnosis Given/Results Found
Neurologist				
ENT				
GI				
Developmental Pediatrician				
Pediatrician				
Other				

Is your child currently on any medications? Yes No

Medication	Dosage	Frequency	Purpose

Please describe your child's general health: \_\_\_\_\_  
 \_\_\_\_\_

Please list any health conditions, surgeries, etc. of note: \_\_\_\_\_  
 \_\_\_\_\_

Has your child had his/her tonsils and adenoids removed? Yes No

Has your child had any ear trouble (earaches, infections)? Yes No

How many? \_\_\_\_\_

Has your child's hearing been tested? Yes No

If yes, when? Results? \_\_\_\_\_

Has your child ever had (PE) tubes inserted? Yes No

If yes, when? \_\_\_\_\_

Has your child's vision been tested? Yes No

Has your child ever worn glasses? Yes No

Does your child currently wear glasses?	Yes	No
Does your child have dental problems?	Yes	No
Has your child had any seizures?	Yes	No
If so, are these treated with medication?	Yes	No

    If yes, please list: \_\_\_\_\_

Were there any noticeable changes in your child's general behavior or speech after a certain life event, illness, surgery, etc.?

	Yes	No
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    If so, explain: \_\_\_\_\_

Does your child have any known <b>skin</b> allergies?	Yes	No
Latex allergy?	Yes	No

Does your child have any **food** allergies or is s/he on a restricted diet? If so, please explain:

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**BIRTH HISTORY**

Is the child adopted?	Yes	No
At what age? _____		

Does your child know they are adopted?	Yes	No
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Were there any complications or illnesses that occurred during pregnancy?

	Yes	No
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    If so, please explain: \_\_\_\_\_

Was any medication taken during pregnancy?	Yes	No
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    If yes, please list: \_\_\_\_\_

Weight at birth _____	Was s/he full-term?	Yes	No
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Type of Birth:	Normal	Induced
	Forceps	Caesarean
	Premature (at ____ weeks)	

Any specific problems/issues at birth?	Yes	No
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    If yes, list: \_\_\_\_\_

How would you describe your child's 1<sup>st</sup> year? \_\_\_\_\_

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**DEVELOPMENTAL HISTORY**

Were developmental milestones met on time? Yes No

Which milestones were met on time?

- |                          |                        |
|--------------------------|------------------------|
| Sits unsupported         | Walks                  |
| Eats solid foods         | Self-feeds             |
| Crawls                   | Self-feeds             |
| Stands alone             | Bladder/bowel trained  |
| Babble                   | Use 2 word combos      |
| Say 1 <sup>st</sup> word | Say Complete sentences |

If milestones were delayed, please elaborate: \_\_\_\_\_

Does your child show aversive reaction to touching certain objects or textures? (Check all that apply).

- |               |              |
|---------------|--------------|
| on hands      | on feet      |
| on mouth/lips | on body      |
| on face       | inside mouth |
| toothbrush    | hair brush   |

When did teeth erupt? \_\_\_\_\_

Last visit to dentist? \_\_\_\_\_

Does your child exhibit bruxism? Yes No

Does your child exhibit thumb sucking? Yes No

Does your child use a pacifier? Yes No

If yes, please describe usage: \_\_\_\_\_

When did you discontinue pacifier usage? \_\_\_\_\_

**SPEECH & LANGUAGE HISTORY**

How does your child communicate? (check all that apply)

- |              |                    |
|--------------|--------------------|
| Eye contact  | Moves person/adult |
| Gestures     | Vocalizations      |
| Jargon       | Sign Language      |
| PECS symbols | AAC device         |
| Words        | Phrases            |
| Sentences    | Conversation       |
| Writing      | Other: _____       |



How does your child take in liquid?	Syringe	Bottle
	Sippy cup (soft spout)	Sippy cup (hard spout)
	Straw cup	Open cup
	360 cup	

Additional Comments on Feeding: \_\_\_\_\_  
 \_\_\_\_\_

Are mealtimes difficult? Yes No

Will she/he try new foods? Yes No

Has your child ever had issues with: Reflux Constipation

If yes, when? \_\_\_\_\_

Current weight: \_\_\_\_\_ Height: \_\_\_\_\_

Does your child have a history of respiratory infections? Yes No

Does your child have a history of recurring pneumonia? Yes No

Has your child ever been by physician for feeding concerns/difficulties?  
 Yes No

If yes, list physician and date(s): \_\_\_\_\_  
 \_\_\_\_\_

Has your child ever had a swallow study performed? Yes No

If yes, when and what were the results? \_\_\_\_\_  
 \_\_\_\_\_

Does your child receive supplemental tube or oral feeding (i.e. Pediasure)?  
 Yes No

If yes, please complete the following:

Amount: \_\_\_\_\_

Frequency: \_\_\_\_\_

Rate: \_\_\_\_\_

Method:

NG	PEG	GEG
Bolus	Oral	

Please describe the seating/positioning your child is in when she/he eats at home:

High chair	Held on lap	Floor
Wheelchair	Booster seat	Feeder seat
Upright	Regular chair	Semi-upright
Reclined	Child roams while eating	

Other: \_\_\_\_\_

Child will eat for:	Mom	Dad	Grandparent
	Nanny	School	Other: _____

Independence of feeding:

Child feeds self

Child is fed by (list all): \_\_\_\_\_

Feeding equipment /utensils used (check all that apply):

Bottle	Nuby cup	Sippy cup
Open cup	Straw	Baby spoon
Toddler fork/spoon	Teaspoon	Standard size spoon
Fork	Adapted utensils	Scoop bowl/plate

Type of bottle, cup, etc.: \_\_\_\_\_

Other: \_\_\_\_\_

List the food/liquid consistencies that your child eats (check all that apply):

Regular/thin liquids	Textured purees	Mashed foods
Nectar thick liquids	Smooth purees	Minced/ground
Honey thick liquids	Regular table foods	Chopped foods

Baby cereals/food

Stage One

Stage Two

Stage Three

### Appetite

Does your child have a limited diet?	Yes	No
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Does your child eat the same foods daily?	Yes	No
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Special diet:

Gluten Free

Dairy/Casein Free

Vegetarian

Vegan

Kosher

No Sugar

Other: \_\_\_\_\_

Please list foods typically served and amount eaten, where applicable.	Amount/Types of Food	Time to finish meal
<b>Breakfast</b>		
<b>Snack 1</b>		
<b>Lunch</b>		
<b>Snack 2</b>		
<b>Dinner</b>		
<b>Snack 3/Dessert</b>		

Check ALL foods/liquids your child currently eats.

Texture

crunchy

crispy

smooth

lumpy

hard

chewy

mixed consistencies

uniform lumpy (cottage cheese)

Taste

salty

sweet

spicy

tart

flavored

bland

Temperature

hot

warm

cold

cool



## Breads

Crackers

Chips

Flour tortillas

Pretzels

Cheese puffs

Pizza crusts

Bagels

Biscuits

Cinnamon rolls

Cornbread

Pies

Pop tarts

Bread:           white                   wheat           rye                   gluten free                   French

Taco Shells

Hamburger/hot dog buns

Texas toast/garlic bread

Rolls

Hot rolls, baked bread, croissants

Muffins

Doughnuts

Banana/apple/pumpkin bread

Cupcakes

Cake

Pastries

## Meats

Baked chicken

Chicken strips

Turkey

Fish (fried)

Tuna salad

Roast

Steak

Veal

Bacon

Meatballs

Lil smokies

Fried chicken

Chicken nuggets

Hot Dogs

Fish (baked or broiled)

Beef

Hamburger

Ham

Pork

Sausage

Baby food meat sticks

## Nuts

Peanut butter

Peanuts

Almonds

Almond Butter

Nutella

Cashews

Pecans

Walnuts

Sun Butter

Other: \_\_\_\_\_

## Potato Products

French fries	Tater tots
Tater rounds	Hash browns
Baked potatoes	Potato chips
Potato wedges	Mashed potatoes
Baked sweet potatoes	Candied sweet potatoes
Sweet potato chips	Scalloped/Au Gratin Potatoes
Veggie Fries	

## Condiments

Ketchup	Mayo
Miracle whip	Mustard
Dijon/Spicy mustard	Honey mustard
BBQ sauce	Chili sauce
Ranch dressing	Butter/Margarine
Honey	Syrup
Cool Whip/Whipped Cream	Cheese Dip
Salsa	Guacamole
Hummus	

## Breakfast Foods

Oatmeal	Cream of Wheat
Pop Tarts	Dry cereal
Pancakes	Cereal w/Milk
Waffles	French toast
Yogurt	Fried Eggs
Scrambled eggs	Omelet
w/cheese	w/cheese
w/veggies	w/veggies
w/meat	w/meat
Hard Boiled eggs	Poached eggs
Go-Gurt	Fresh fruit
Bacon	Sausage
Ham	Grits

Oatmeal Bites  
Breakfast shakes  
Cinnamon raisin bread  
Granola bars

Toast: w/butter  
w/jelly  
w/peanut butter

Other: \_\_\_\_\_

### Vegetables

Green beans  
Cauliflower  
Squash  
Zucchini  
Carrots  
Cabbage  
Asparagus  
Brussel sprouts

Broccoli  
Corn  
Cucumber  
Spinach  
Lettuce  
Avocado  
Mushrooms  
Onion

Peppers: Bell red yellow

Peas: English black eyed

Beans: black kidney pinto

white garbanzo

### Fruits (circle specifics)

Apple: red green yellow

Banana

Blueberry

Cantaloupe/Honey Dew

Cherry

Grapes

Kiwi

Lemon

Lime

Orange

Pears

Pumpkin

Watermelon

Pineapple

Raspberry

Mango

Strawberry

Tangerine/Clementine

Tomato

### Dried Fruits

Cherries

Raisins

Blueberries

Oranges

Bananas

## Soups

Cheese

Stew

Egg drop

Chicken noodle

Cheese & Broccoli

Miso

Chili

Vegetable

Beef noodle

Chicken & Rice

Cheese & Vegetables

Plain Broth

## Pasta/Rice

Brown Rice

Quinoa

Pasta:

Penne

Spaghetti

Elbow

White Rice

Mac N Cheese

Sauce:

Red Sauce

Alfredo

Pesto

## Combination Foods

Spaghetti w/meat balls/sauce

Baked Ziti

Casseroles: \_\_\_\_\_

Lasagna

Pizza (list toppings) \_\_\_\_\_

\_\_\_\_\_

## Cheese

Cheddar

Parmesan

Monterey jack

Cottage cheese

Sour Cream

Shredded

American

Swiss

Colby

String cheese

Cream Cheese

Sliced

## Liquids

Water

Milk (whole, 2%, skim)

Soda

Unsweetened tea

Floats

Caloric supplements: \_\_\_\_\_

Flavored milk

Tea

Sweet tea

Milk shakes

Drinkable yogurt

Protein/Meal Replacement Shakes

**Juice**

Apple

Orange

Berry

Grape

Fruit punch

White grape

Pear

Prune

Strawberry

Kiwi

Cranberry

**Comments:**

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Please check the characteristics that your child exhibits during meals:

OBSERVATIONS	FOODS	LIQUIDS
Coughing		
Gagging		
Vomiting		
Choking		
Eyes watering		
Changes in breathing		
Change in color of face(becomes, red, pale, etc.)		
Food comes out of nose		
Fatigue/falls asleep		
Head thrown back when eating/swallowing		
Spillage food without chewing		
Swallows food without chewing		
Takes very large bites		
Excessive time to manipulate bites		
Nibbles on food		

OBSERVATION	FOODS	LIQUIDS
Overstuffing		
Storing/holding in mouth (time: _____)		
Requires support at chin/lips/jaw for closure/swallow		
Pushes food /utensil away		
Pushes adult away		
Crying		
Hitting		
Kicking		
Screaming		
Self-injurious behaviors		
Throwing food/utensils/tray		
Spitting		
Prompt dependent to take bites		
Plays with food		
Increased stress/anxiety levels		

**EDUCATIONAL HISTORY**

Child's current school: \_\_\_\_\_

Please list all previous schools and years attended: \_\_\_\_\_

Current grade: \_\_\_\_\_

Has your child repeated a grade? Yes No

If yes, which grade? \_\_\_\_\_

Indicate performance level in school: Below Average Average Above Average

Did your child attend nursery school and/or pre-K? Yes No

If yes, where? \_\_\_\_\_

Does your child like school? Yes No

Does your child receive services through any of the following:

EIP Tutoring

IEP 504 plan

If yes, please list services and frequency: \_\_\_\_\_

**THERAPY:**

Please provide information on therapies your child currently receives.

Therapy	Frequency	Therapist Name/Practice
Speech		
Feeding		
Occupational		
Physical		
ABA		
Floor Time		
Music		
Nutrition		
Other		

**BEHAVIOR/SOCIAL:**

Does your child play: Alone with older children  
with peers with younger children

Does your child have close friends? Yes No

What are your child's most frequent discipline problems? \_\_\_\_\_

Who handles discipline? \_\_\_\_\_



How is the child disciplined? \_\_\_\_\_

Please list your child's strengths when interacting with peers: \_\_\_\_\_

Please list concerns you have about your child's interactions with peers: \_\_\_\_\_

**OTHER COMMENTS:**

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