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? _____

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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

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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

If so, explain: _____

_____

Does your child have any known **skin** 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:

_____

_____

_____

BIRTH HISTORY

Is the child adopted? ☐ Yes ☐ No

At what age? _____

Does you child know they are adopted? ☐ Yes ☐ No

Were there any complications or illnesses that occurred during pregnancy? ☐ Yes ☐ No

If so, please explain: _____

Was any medication taken during pregnancy? ☐ Yes ☐ No

If yes, please list: _____

Weight at birth _____ Was s/he full-term? ☐ Yes ☐ No

Type of Birth: ☐ Normal ☐ Induced ☐ Forceps ☐ Caesarean ☐ Premature (at ____ weeks)

Any specific problems/issues at birth? ☐ Yes ☐ No

If yes, list: _____

How would you describe your child's 1st year? _____

_____

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DEVELOPMENTAL HISTORY

Were developmental milestones met on time? ☐ Yes ☐ No

Which milestones were met on time?

- ☐ Sits unsupported
- ☐ Eats solid foods
- ☐ Crawls
- ☐ Stands alone
- ☐ Babble
- ☐ Say 1st word
- ☐ Walks
- ☐ Self-feeds
- ☐ Self-feeds
- ☐ Bladder/bowel trained
- ☐ Use 2 word combos
- ☐ 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 mouth/lips
- ☐ on face
- ☐ toothbrush
- ☐ on feet
- ☐ on body
- ☐ inside mouth
- ☐ 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 you 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
- ☐ Gestures
- ☐ Jargon
- ☐ PECS symbols
- ☐ Words
- ☐ Sentences
- ☐ Writing
- ☐ Moves person/adult
- ☐ Vocalizations
- ☐ Sign Language
- ☐ AAC device
- ☐ Phrases
- ☐ Conversation
- ☐ Other: _____

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What efforts does your child make to communicate his/her wants when not understood?

_____

Is your child's speech understandable to: ☐ family? ☐ friends? ☐ strangers?

Did speech learning ever seem to stop for a period? ☐ Yes ☐ No

If so, describe: _____

Can your child follow directions? ☐ Yes ☐ No

☐ 1 step direction
☐ 2 steps
☐ 3 steps

Please rate your child's attention:	**Good**	**Fair**	**Poor**
Preferred tasks	☐	☐	☐
Non Preferred tasks	☐	☐	☐
Academic tasks	☐	☐	☐
During interactions with others	☐	☐	☐

What have you done to help your child's speech and language?

_____

_____

FEEDING DEVELOPMENT/HISTORY

Were there any feeding problems in early life? ☐ Yes ☐ No

If so, describe: _____

_____

Are there any present eating problems? ☐ Yes ☐ No

If so, describe: _____

_____

Does s/he have difficulty chewing or swallowing? ☐ Yes ☐ No

Does s/he drool? ☐ Yes ☐ No

Is your child a picky eater? ☐ Yes ☐ No

How many food items are in your child's diet? ☐ <5 ☐ 5-10 ☐ 10-20 ☐ 20+

What are your child's favorite foods? _____

_____

Is there anything your child refuses to eat? _____

Does your child use utensils? ☐ Yes ☐ No

Do they feed themselves? ☐ Yes ☐ No

If not, who feeds the child: _____

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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

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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

<u>Appetite</u>

Does your child have a limited diet? ☐ Yes ☐ No

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**
Breakfast		
Snack 1		
Lunch		
Snack 2		
Dinner		
Snack 3/Dessert		

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

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Breads

- ☐ Crackers
- ☐ Chips
- ☐ Flour tortillas
- ☐ Pretzels
- ☐ Cheese puffs
- ☐ Pizza crusts
- ☐ Bagels
- ☐ Biscuits
- ☐ Cinnamon rolls
- ☐ Cornbread
- ☐ Pies
- ☐ Pop tarts
- ☐ 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

Bread: ☐ white ☐ wheat ☐ rye ☐ gluten free ☐ French

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: _____

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Potato Products

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

Condiments

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

Breakfast Foods

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

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- [ ] 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
- [ ] Peppers: [ ] Bell [ ] red [ ] yellow
- [ ] Beans: [ ] black [ ] kidney [ ] pinto [ ] white [ ] garbanzo
- [ ] Broccoli
- [ ] Corn
- [ ] Cucumber
- [ ] Spinach
- [ ] Lettuce
- [ ] Avocado
- [ ] Mushrooms
- [ ] Onion
- [ ] Peas: [ ] English [ ] black eyed

Fruits (circle specifics)

- [ ] Apple: [ ] red [ ] green [ ] yellow
- [ ] Blueberry
- [ ] Cherry
- [ ] Kiwi
- [ ] Lime
- [ ] Pears
- [ ] Watermelon
- [ ] Raspberry
- [ ] Strawberry
- [ ] Tomato
- [ ] Banana
- [ ] Cantaloupe/Honey Dew
- [ ] Grapes
- [ ] Lemon
- [ ] Orange
- [ ] Pumpkin
- [ ] Pineapple
- [ ] Mango
- [ ] Tangerine/Clementine

Dried Fruits

- [ ] Cherries
- [ ] Blueberries
- [ ] Bananas
- [ ] Raisins
- [ ] Oranges

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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

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Juice

- ☐ Apple
- ☐ Berry
- ☐ Fruit punch
- ☐ Pear
- ☐ Strawberry
- ☐ Cranberry
- ☐ Orange
- ☐ Grape
- ☐ White grape
- ☐ Prune
- ☐ Kiwi

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		

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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		

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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? _____

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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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