MULTIDISCIPLINARY PEDIATRIC FEEDING PROGRAM
SCREENING QUESTIONNAIRE

Today's Date:

QUESTIONNAIRE PAGE ___ OF ___

BACKGROUND INFORMATION

1. Child's Name:	2. Date of Birth: / /	3. Gender: ☐ *Male* ☐ *Female*
4. Parent/Guardian(s) Name(s):	5. Marital Status: ☐ *Married* ☐ *Single* ☐ *Divorced* ☐ *Separated* ☐ *Widowed* ☐ *Other:*_____________	

6. List of People Currently Living in the Household:

Name	Relationship to Child	Age

7. What is your major concern regarding your child's feeding?

8. Referring Source:

MEDICAL HISTORY

9. Current medications *(please include all prescriptions, vitamins, over-the-counter medications, and herbal or alternative remedies)*:

10. Allergies:	11. Allergy Test(s): *(Please include date of tests)* ☐ Blood: ____/____/____ ☐ Skin Patch: ____/____/____ ☐ Skin Prick: ____/____/____ ☐ Endoscopies: ____/____/____

12. Has your child been diagnosed with a medical condition? ☐ *Yes* ☐ *No* (e.g. Failure to Thrive, Pre-maturity, Congenital Heart Defect etc)

Date of Evaluation/Diagnosis	(Type of Evaluation)	Results/Diagnosis	Name of Doctor/Evaluator

13. Surgical History: *Has your child had any surgeries)?* ☐ *Yes* ☐ *No*

Type of Surgery	Age

14. Medical Procedures: *(i.e. endoscopies, radiology testing, upper GI, swallow study, motility study, other GI tests etc)*

Procedure/Reason for Hospitalization	Date

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15. Significant Illnesses or Hospitalizations:

Illness/Reason for Hospitalization	Date/Age

16. Family History: ☐ *Medical Problems* ☐ *Psychiatric or Psychological Problems* ☐ *Developmental Delay* ☐ *Feeding Difficulty*

Family Member	Relationship to Patient	Diagnosis

BIRTH INFORMATION

17. Baby was born: ☐ *Full Term* ☐ *Pre-term (Gestational Age: ______)*

18. Birth Weight:

19. Type of delivery: ☐ *Vaginal* ☐ *Caesarian Section:* ☐ *planned* ☐ *emergency*

20. Complications or problems noted? ☐ *During Pregnancy* ☐ *After Birth* ☐ *None*
    Comments:

21. Did your child stay in the Neonatal ICU? ☐ *No* ☐ *Yes: Duration _______*
    Comments/Reason for Stay?

DEVELOPMENTAL INFORMATION

22. Has your child been diagnosed with a developmental disability or as having behavioral problems? ☐ *Yes* ☐ *No* (e.g. ADD/ADHD, autism spectrum disorders, oppositional behavior, aggressive behavior, speech delay, motor delay, sensory problems, learning problems etc)

Date of Evaluation/Diagnosis	Type of Evaluation	Results/Diagnosis	Name of Doctor/Evaluator

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23. Please list the approximate ages at which the child was able to:

Sit Alone		*Crawl*		*Toilet Trained* (bowel/bladder)	
Walk Alone		*First Words*		*Spoke Sentences*	

24. Is your child attending school, early intervention program, day care or other community activity?

Name of Facility	**Date Enrolled**	**How Often**

25. Please list any therapy or support services your child currently receives or has received in the past (i.e. speech therapy, occupational therapy, physical therapy, feeding therapy ABA/behavior therapy, regional center, early intervention, psychology?

Date of Treatment From____ to_____	**Treatment Program/Therapist/Specialist**	**Problem(s) Addressed**	**Reason for Cessation of Treatment**

FEEDING HISTORY

26. Is your child currently working with a dietician? ☐ *Yes* ☐ *No*
Please list name, how often and goals if applicable:

27. What modes of feeding do you currently use or have used in the past?

Feeding method	**Age introduced/how long?**	**Any Problems Noted/Comments**
☐ *Breast-fed*		
☐ *Bottle-fed*		
☐ *Finger Feeds*		
☐ *Spoon*		
☐ *Fork*		
☐ *Knife*		
☐ *Straw Drinking*		
☐ *Sippy Cup*		
☐ *Open Cup Drinking*		
☐ *Feeding tube:* (circle one) *G-tube* *NG tube* *NJ tube*		
☐ *Other:* _____		

28. What formula(s) does your child currently take by mouth?

29. What formula(s) does your child currently take via feeding tube?

30. Approximate % daily intake taken by the tube?

31. Amount of formula fed (cc's or calories/child's weight):

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32. Please describe your child's feeding schedule:

33. Please check the box that describes your child's current intake of each of the following food types:

CONSISTENCY	Does eat	Can eat	Cannot eat	Wont eat	Never tried	Comments
Regular liquid	☐	☐	☐	☐	☐	______
Thick liquid	☐	☐	☐	☐	☐	______
Stage 1 or 2 baby food	☐	☐	☐	☐	☐	______
Food prepared in blender	☐	☐	☐	☐	☐	______
Ground or Stage 3 baby food	☐	☐	☐	☐	☐	______
Mashed table food	☐	☐	☐	☐	☐	______
Chopped table food	☐	☐	☐	☐	☐	______
Regular table food	☐	☐	☐	☐	☐	______
Crisp food (crackers)	☐	☐	☐	☐	☐	______
Chewy food (meat)	☐	☐	☐	☐	☐	______
Crunchy food (carrot)	☐	☐	☐	☐	☐	

34. Please list various foods, flavors, textures that are favorites/easy or dislikes/difficult

Favorite/Preferred/Easy	Dislikes/Refuses/Difficult

35. How does your child let you know he/she is hungry?

36. Who usually feeds your child?

37. Which other individuals can feed your child? What is their relationship to your child?

38. Where is the child usually fed?

☐ *Lap* ☐ *Table/Chair* ☐ *High Chair* ☐ *Stand/Roam*
☐ *Infant Seat* ☐ *Floor* ☐ *Couch* ☐ *Other:* ________________

39. Describe the environment/location:

40. How long do meals typically last?

41. How much food is your child able to finish in a typical meal?

42. Please check any behaviors that are of concern to you. Please circle the behavior(s) most concerning to you.

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☐ *Eats too fast*	☐ *Eats non-food items*	☐ *Vomits*	☐ *Pushes food away*
☐ *Eats too much*	☐ *Uses a bottle*	☐ *Drools*	☐ *Fails to suck*
☐ *Refuses to open mouth*	☐ *Reflux*	☐ *Messy eater*	☐ *Throws or drops food*
☐ *Spits food out*	☐ *Eats too little*	☐ *Leaves table*	☐ *Cries or Tantrums*
☐ *Turns away from food*	☐ *Fails to chew food*	☐ *Ruminates*	☐ *Plays with food*
☐ *Refuses to swallow food*	☐ *Gags*	☐ *Eats too slow*	
☐ *Picky eater*	☐ *Sneaks or steals food*	☐ *Other:* ____________	

43. Please check any techniques that you have used to get your child to eat. Please circle the technique(s) that are the most effective

☐ *Threaten*	☐ *Forced feeding*	☐ *Model*	☐ *Limit foods*
☐ *Coax*	☐ *Change food offered*	☐ *Spank*	☐ *Offer small meals*
☐ *Offer reward*	☐ *Distract with play/toys*	☐ *Praise*	☐ *Ignore*
☐ *Send to time-out*	☐ *Change meal schedule*	☐ Use TV/Video	☐ *Other:*

44. What are your goals for therapy? (check all that apply)

☐ *Increase amount of food*	☐ *Decrease/eliminate tube feeds*	☐ *Decrease vomiting related to eating*
☐ *Increase variety of foods*	☐ *Increase the textures of food*	☐ *Resolve reflux or other GI issues*
☐ *Improve mealtime behaviors*	☐ *Improve oral motor skills*	☐ *Other:*
☐ *increased weight gain*	☐ *Decrease gagging during eating*	

ADDITIONAL COMMENTS

45. Please list any additional information you feel is important to the evaluation and treatment of your child.

____

____

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____

____

____

____
Print Parent Name

_______________________________ _______________
Signature Date

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