More Than Words… Therapy Services, LLC
215-A Dunbar Cave Rd | Clarksville, TN 37043
Telephone: 931.542.2739 | Fax: 931.233.9970
Website: www.MoreThanWordsLLC.com
Facebook: MoreThanWordsTherapy

Pediatric Feeding Questionnaire

Dear Parent:

Having a child who does not feed well is a worrisome, frustrating, confusing and at times, medically concerning problem. We, at More Than Words … Therapy Services, understand how complex feeding difficulties can be. Because of these complexities, we believe it is important to look at the "whole" child and to assess all the possible contributing factors in a feeding problem through the use of a Multidisciplinary Evaluation approach. We are committed to helping you and your child identify what is interfering with your child's eating and how to improve their growth and interactions with food.

In order to best help us prepare for your child's evaluation, we would like you to carefully read over the following information and to complete the enclosed questionnaire in as much detail as possible. Many items on the forms can be simply answered by checking YES or NO in the appropriate space. If you give a YES response, please explain this answer thoroughly in the space provided or on the back of the page. If you cannot, or wish to not answer a question, leave it blank. If a question does not apply to your child, you may write in N/A for "not applicable."

Please bring your forms with you to your appointment and arrive approximately 15 minutes prior to your scheduled appointment time so our staff can review the paperwork.

THE FEEDING APPOINTMENT

On the day of your appointment, the Evaluation Team will be observing your child, yourself, and preferably all other major caretakers having a snack together. The speech language pathologist assigned as your Case Manager will ask you any questions the therapist has after completing the observation and reviewing the information you provide in this packet as well as providing feedback and recommendations.

For the appointment, we would like you to **bring at least 2 foods of different textures and 1 drink that your child will most likely eat, and at least 1 food your child will most likely refuse.** We want to be able to evaluate your child's current skill level, as well as determining how they handle more challenging foods.

Please also **pack your child's preferred utensils, cup, bottles, and dishes** to make the assessment situation as "home-like" as possible. We find it helpful to explain to older children that you are packing a "picnic" to eat together at the Doctor's office and that these doctors' job is to help children and families learn to eat better together. We also ask that you **NOT feed them for at least 1.5 hours before** their scheduled appointment time.

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Child's Name: ______________________________ **DOB:** ______________________________

Please explain, in your own words, what your child's current feeding problem is: ______________________________

____

____

Did you have a normal pregnancy and delivery? __________ If NO, please explain: ______________________________

____

____

Was your child a preemie? __________ If YES how long was he/she in the NICU and how did feedings take place (NG tube, bottle, breast, etc) ______________________________

____

____

Does your child have any medical conditions or diagnoses (ex. Autism, acid reflux) ______________________________

____

____

What illness or surgical procedures has your child had?

____

____

____

Is a dietitian working with your child? If yes, who and how often? ______________________________

____

____

Is your child receiving other therapies? If yes, what kind and with whom? ______________________________

____

____

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Was your child breast fed? From when to when? ______________________________

Was your child bottle fed? From when to when? ______________________________

Please describe your child's initial skill on the breast and/or bottle. ______________________________

____

____

During these early feedings, did your child frequently arch, cry, spit up, gag, cough, vomit, or pull off the nipple? Circle the behaviors shown and describe when they would happen, why, for how long. ______________________________

____

____

Describe how the weaning process off the breast and/or bottle went and why the child was weaned: ______________________________

____

____

At what age did your child transition to baby cereal? ______ Baby food? ______ Finger foods? ______ Transition fully to table food? ______

Please describe how these transitions were handled by your child, especially if any difficulties happened? ______________________________

____

____

How often does your child eat and drink? What are his or her usual meal and snack times? ______________________________

____

____

List the food that your child currently will eat and drink (put a star next to their favorites.): ______________________________

____

____

List the foods your child refuses: ______________________________

____

____

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List the foods your child is allergic to: ____

____

____

Describe your child's mealtime:

Who typically feeds your child? ____

Who typically eats with your child? ____

What type of chair is used? ____

How long are meals typically? ____

Does your child use utensils or any type of special cups/bowls (describe)? ______________________________

____

____

Are there any other activities going on at meals? What activities (describe)? ______________________________

____

____

What times does your child typically eat and what type (bottle, breast, solids)? ______________________________

____

____

Has your child ever been on any type of special diet other than what you just describe? __________ If yes, please describe type of diet, at what ages, why and what your child's response: ______________________________

____

____

How do you know your child is hungry or full? ____

____

____

Has your child lost or gained any weight in the last 6 months, and how much? ______________________________

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Would you describe your child's weight loss as (circle one): Ideal Underweight Overweight

Does your child have/had any of the following problems: Dental, frequent constipation, frequent diarrhea, vomiting, choking, gagging, coughing? Please describe: ______________________________

____

____

Does your child take a vitamin supplement? Which one? ______________________________

Describe how you, and your child feel after feeding:

You: ______________________________

Your child: ______________________________

What other evaluations have been completed regarding your child's feeding difficulties and what the results/what were you told? __________

____

____

What treatments have been tried for this problem, and what were the results? ______________________________

____

____

How can we be most helpful to you and your child? ______________________________

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____

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IF YOUR CHILD IS TUBE FED, PLEASE ANSWER THE FOLLOWING QUESTIONS:

What type of formula is used and how do you mix it? ____

____

Please detail your child's feeding schedule below.

Time of feeding (Start)	NG, G or Continuous	Amount	Gravity or Pump	Over what time/rate

Describe where your child is tube fed and what activities are occurring at the same time: ______________________

____

____

Describe your child's reactions to the tube feedings (connecting, during, disconnecting): ______________________

____

____

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3 Day Diet History Form

Instructions:

You are being asked to record all foods and drinks consumed by your child for three days in a row. The following directions will guide you in filling out the form. You need to complete this history and bring it to the evaluation with the rest of your forms.

1. Please fill out ALL the information at the top of the first page.

2. Please record the DATE and DAY of the week for each day. Record ALL food and drinks eaten along with the TIME your child ate or drank them. It is best to carry the history form with you and record items immediately so that nothing is missed.

3. Include an EXACT description of the item and your best guess of the portion size of the amount eaten. Write the brand name of formula your child is on (i.e. Enfamil, Prosobe, etc), what type of juice he/she drank (i.e. apple, grape), any special recipes for drink mixtures your child uses (i.e. 24 calorie Isomil + 1 tsp Polycose), and any additions to foods (i.e. ¼ cup mashed potatoes + 1 Tbsp margarine). Be sure to include dressings, sauces, gravies, or anything extra.

4. It is suggested that you may wish to use measuring spoons and cups when serving your child for these 3 days to report the amounts eaten/drunk with more accuracy.

Example:

Date	Time	Food/Drink Item	Amount	Utensil/Fingers	Bottle	Cup	G-Tube
1/15	4pm	Gerber Applesauce #2	1oz	Spoon			
		White Bread	¼ slice	Fingers			
		Ham lunch meat	½ oz	Fingers			
		White grape juice	1 oz			X	
	7 pm	Simlac Formula	4 oz		X		
	9pm	Pediasure w/fiber	8 oz				X

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Child's Name: ______________________________ **DOB:** ______________________

Parent/Guardian Name: __________________________ **Daytime Phone** ______________

Vitamin or Mineral Supplement ________ NO ________ YES Name & Amount: ______________________________

Date	Time	Food/Drink Item	Amount	Utensils/ Fingers	Cup	Bottle	G-tube

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Food Preferences Checklist

Instructions: Check the box beside food items that your child typically eats (“typically is defined as greater than 50% of the time that it is offered.)

PROTEINS:

☐ Chicken, Roasted/Baked	☐ Chicken, Fried	☐ Chicken Nuggets	☐ Turkey
☐ Bacon	☐ Ground Beef	☐ Fish Sticks	☐ Fish Fillets
☐ Tuna Salad	☐ Sausage	☐ Ham	☐ Hot Dogs
☐ Meat Sticks/Vienna Sausage	☐ Pork Chops	☐ Potted Meat	☐ Hummus
☐ Roast Beef	☐ Steak	☐ Lamb Roast/Chop	☐ Yogurt
☐ Edamame (Soy Beans)	☐ Tofu	☐ Eggs	☐ Cottage Cheese
☐ Peanut Butter	☐ Nuts	☐ Cheese: ______________	☐ Baked Beans
☐ Prepared Baby Food Meats: _________________________		☐ Other: ____________________________________	

BREADS / STARCHES:

☐ Bread, Sliced	☐ Pancakes	☐ Waffles	☐ French Toast
☐ Bagels	☐ Biscuits	☐ Donuts	☐ Grits
☐ Hot Cereal: ______________________________________		☐ Cold Cereal: ______________________________	
☐ Pretzels	☐ Rice Cakes	☐ Popcorn	☐ Cake
☐ Cookies	☐ Chips	☐ French Fries	☐ Rice
☐ Mashed Potatoes	☐ Baked Potato	☐ Macaroni/Pasta	☐ Macaroni & Cheese
☐ Flour Tortillias	☐ Corn Tortillias	☐ Other: ____________________________________	

VEGETABLES:

☐ Green Beans	☐ Lima Beans	☐ Broccoli	☐ Spinach
☐ Carrots	☐ Peas	☐ Zucchini	☐ Squash
☐ Avocado	☐ Beets	☐ Cabbage	☐ Asparagus
☐ Tomatoes	☐ Corn	☐ Okra	☐ Lettuce
☐ Cooked Greens	☐ Cucumbers	☐ Cole Slaw	☐ Sweet Potatoes
☐ Other: ____________________________________			

FRUITS:

☐ Apples	☐ Apple Sauce	☐ Peaches	☐ Pears
☐ Strawberries	☐ Raisins	☐ Cherries	☐ Pineapple
☐ Kiwi	☐ Grapes	☐ Banana	☐ Oranges
☐ Mandarin Oranges	☐ Fruit Cocktail	☐ Cantaloupe	☐ Grapefruit
☐ Watermelon	☐ Honeydew Melon	☐ Other: ____________________________________	

BEVERAGES / DRINKS:

☐ Milk	☐ Soy or Rice Milk	☐ Fruit Juice (100%)	☐ PediaSure
☐ Instant Breakfast	☐ Fruit Juice Blends (Hi-C)	☐ Soda	☐ Kool-Aid
☐ Tea	☐ Gatorade	☐ Water	☐ Coffee
☐ Other: ____________________________________			

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