The following is a comprehensive questionnaire that we request you fill out prior to attending your feeding and swallowing assessment. Although we recognize it is lengthy, gathering this information ahead of time will allow more time for direct assessment of your child. Please be as detailed as possible. Not all questions will apply to all children. Please feel free to skip over all non-applicable questions.

Identifying Information:
Child's Name: _____DOB:_____
Parents:_____
Address:_____
Phone: (H): _____(W/C):_____
Referral Source:_____
Insurance: _____
Primary Pediatrician (including address):
_____
_____

What is your primary concern? (Check all that apply)

___ Not eating enough variety
___ Not eating enough volume
___ Eating too much
___ Food refusal
___ Poor growth
___ Transitioning from tube to oral feeding
___ Gagging
___ Vomiting
___ Avoiding whole food groups
___ Only eats purees
___ Only eats crunchy solids
___ Only drinks fluids
___ Aspiration
___ Constipation
___ Diarrhea
___ Toothbrushing intolerance

Birth History:
___ Full term ___ Premature (_____weeks)
___ Spontaneous Vaginal Delivery ___ C-Section ___ Induced
Reason for C-section or induction: _____
Please describe any complications during pregnancy: _____
_____
Did your child have a NICU stay? ____If so, for how long?_____
Did your child require oxygen? ____ If so, for how long? _____
Was your child intubated? ____ If so, for how long? _____
When did your child leave the hospital? (with mother, other time)
_____
_____

Feeding History:
When did you first notice your child had difficulty eating?_____
As a newborn, was your child bottle fed/breast fed/tube fed?

_____
How did that go? (i.e. refusal, gagging, vomiting, etc.)

_____
When did you introduce purees?_____
How did that go?_____
When did you transition to chewable solids?_____
How did that go?_____

Current Feeding:
How does your child currently receive liquids? _____
If tube fed, what type of tube does your child currently use?
___ ng-tube ___ g-tube ___ g-j-tube ___ j-tube
If tube fed, please list type of formula, times of feedings, rate of feedings, and total volume of feedings (i.e. 120cc bolus over one hour, five times per day)

_____
_____

If fed orally or orally with supplemental tube feeding, please fill out the attached one-day food intake sheet (see attached)

Please indicate which foods your child currently avoids. (Check all that apply)
___ fruits ___ vegetables ___ meats ___ starches
___ purees ___ lumpy ___ crunchy ___ solid
___ fluids ___ mixed textures___ salty ___ sweet
___ spicy

Typical Mealtime:
Who does your child eat with?

_____
Where does your child eat?

_____
Do you use the television, toys, etc. as distractions during meals?

_____

What is the general feeling at your mealtimes? (pleasant, stressful, power struggle) _____

Developmental History:
Does your child currently receive any therapy services?

Therapy	Frequency	Location	Treating Clinician
___ Speech/Language			
___ OT			
___ PT			
___ Feeding therapy			
___ Dev'l Educator			
___ Other			

At what age did your child…?
Babble: _____
Say first words: _____
Combine words: _____

How well do familiar and unfamiliar listeners understand your child?
_____
Do you have concerns regarding how your child understands language? (i.e. follow directions, comprehend concepts, etc.)
_____

At what age did your child…?
Sit up unsupported: _____
Crawl: _____
Walk: _____

Does your child feed him/herself? _____

Medical History:
Does your child currently have a diagnosis? ____
If so, what is it? _____
Does your child have any allergies? _____ If so, please list:
_____
Please list any foods we may NOT offer your child due to personal food diets, religious preferences, etc._____

Please list any medications your child takes:
Types:

_____

Amounts:

_____

Time given:

_____

Has your child had a hearing test? ____ What were the results?_____

_____

Does your child currently or has your child ever had ear tubes?

_____

Has your child had any surgeries? ____ When did they occur and what were they for? _____

_____

Has your child had any procedures? ____(i.e. pH probe, barium swallow)
When did they occur and what were they for?

_____

Has your child ever had a videofluoroscopic swallow study? ____
When? _____ Results: _____

_____

Is your child followed by a dietician? _____
Recent weight: _____ When was this taken? _____
Recent length/height: _____ When was this taken? _____

*If possible, please bring copies of all pertinent reports.

ONE DAY FOOD INTAKE

Please fill out this one day food intake completely. List the time of day food or liquid is offered (by mouth or tube), what that food or liquid item is (if brand specific – include brand), and the volume your child ingested. Please use objective measurements such as 2oz of puree, ¼ cup of pasta, or ½ of a baby carrot, rather than subjective ones such as a handful of cereal, five spoonfuls of pasta, or six sips of milk.

TIME OF DAY	FOOD ITEM OFFERED	VOLUME INGESTED

Please circle: typical day less than average more than average

Please bring one preferred food item, one non-preferred food item and your child's formula, bottle or cup to the appointment.