

Feeding Clinic Questionnaire

Child's Name: _____ **DOB:** ____/____/____ **Age:** ____
Address: _____
Phone: Home: () _____ **Cell:** () _____
Child Lives: Home: _____ Foster home: _____ Other: _____

Parent's Name: _____
Address (if different than child's) _____
Phone: Home () _____ **Cell:** () _____ **Work:** () _____
Email: _____
Occupation _____

Parent's Name: _____
Address (if different than child's) _____
Phone: Home () _____ **Cell:** () _____ **Work:** () _____
Email: _____
Occupation _____

List all Medical Diagnoses and Reason for Referral:

Primary Physician / Practitioner: _____ **Phone:** _____
Clinic: _____
Address: _____

Specialists:

Please list all Specialists involved in the child’s care, including GI specialists:

Phone: () _____
Phone: () _____
Phone: () _____
Phone: () _____

MEDICAL INFORMATION / FAMILY HISTORY:

Current Medications (include Inhalers/Nebulizations and any Vitamin / Herbal Supplements):

_____ Dose / Times per day
_____ Dose / Times per day
_____ Dose / Times per day
_____ Dose / Times per day
_____ Dose / Times per day

Allergies:

_____ Reaction:
_____ Reaction:
_____ Reaction:
_____ Reaction:

Birth History:

Term : _____ (# of weeks) Premature : _____ (# of weeks)

Birth Weight: _____ Length: _____ Apgar Scores: _____

Please list any significant birth history (i.e. - difficult delivery, use of oxygen, extended length of stay in the hospital / NICU, use of ventilator, ect...)

Was the child breast fed? Yes No Age started _____ Age Stopped: _____

Did your child transition well to bottle feedings? Yes No N/A

Please list any surgical procedures the child has had: _____

List any family (immediate / extended) medical history of feeding / eating disorders, GI disorders, food peculiarities. Please include ages especially for siblings: _____

Has your child had any of the following tests?

UGI (upper GI study):

When: _____

Where: _____

Results: _____

VFS (swallow study)

When: _____

Where: _____

Results: _____

Endoscopy:

When: _____

Where: _____

Results: _____

Milk Scan:

When: _____

Where: _____

Results: _____

pH Probe:

When: _____

Where: _____

Results: _____

List the child's normal bowel pattern: _____ times/day.

Chronic constipation? Yes No

Chronic diarrhea? Yes No

Blood in stool? Yes No

Is there an usual foul odor to stools? Yes No

Is your child vomiting? Yes No if yes, how frequently, times of day, with feeding, after feeding ect... _____

Has your child had? (check all that apply)

Frequent Cold Bronchitis Pneumonia Asthma

Bronchial Malacia Laryngeal Malacia Tracheal Malacia BPD

History of Aspiration Use of Oxygen

Tracheostomy - Date placed: _____ Date removed _____

Reason for tracheostomy: _____

Do you receive PCA hours, Nursing hours, Home care visits from Children's Hospitals & Clinics of MN? _____

Vision Information:

Does the child have any vision problems? Yes No

If yes, what are they: _____

Date of most recent vision test: _____ Results: _____ By Whom? _____

Hearing Information

Is there a history of ear infections? Yes No

Have PE tubes been placed? Yes No Date: _____

Does the child have any hearing difficulty? Yes No If so, please describe

Does the child seem overly sensitive to sounds? Yes No

Therapeutic History:

Does the child receive **Speech-Language Therapy**? Yes No

Where: _____ How often: _____

Program Emphasis: _____

Therapist: _____

Address: _____

Does the child receive **Occupational Therapy**? Yes No

Where: _____ How often: _____

Program Emphasis: _____

Therapist: _____

Address: _____

Does the child receive **Physical Therapy**? Yes No

Where: _____ How often: _____

Program Emphasis: _____

Therapist: _____

Address: _____

Education:

Does the child currently attend school or receive other school services (such as ECSE teacher, B-3 program, County program, Vision Therapist ect...)? Yes No

If yes, which County and State? _____

Where _____ Grade _____

Special Education Services: _____

(Please attach a copy of the child's IEP or IFSP if available)

Has the child had an evaluation by a Psychologist? Yes No

If so, Where? _____ Frequency _____

Therapist: _____ Phone: _____

Are you having any problems managing the child's behavior related to feeding? (i.e.- refusal to eat, vomiting, eating very slowly, tantrums) please specify: _____

Do you have any other concerns about the child's behavior at home or school? _____

Nutrition and Feeding

Current weight: _____ Height: _____ Date: _____

Does the child have difficulty gaining weight? Yes No

Have there been past or present nutritional concerns? Yes No

What help have you had in managing nutrition? (i.e.- Dietitian from Pediatric Home Services, Nutritional consultations, Primary doctor's suggestions, special formula, foods ect...) _____

Does the child have (check all that applies)

G-tube J-tube Start: _____ Stop: _____
 NG Tube Oral tube Start: _____ Stop: _____

Why were tubes placed?: _____

How many tube feedings per day does the child receive? _____

Bolus? _____ Drip? _____

What is the rate per feeding (cans/day or cc/day)?: _____

Type of formula (with or without fiber) _____

List any Home Care agency you use for formula and/or tube supplies: _____

Is the child drinking from: (check all that applies)

Breast: Yes No How Often? _____ How long on each breast? _____

Bottle: Yes No How Often? _____ How many ounces per feeding? _____

Cup: Yes No How Often? _____ How many ounces per feeding? _____

Does the child know how to use a straw? Yes No

Do you need to assist with cup drinking? Yes No

What type of formula/milk do you use for oral feedings? _____

(Please indicate if it has fiber or if you mix it to a higher concentration than regular formula)

Do you mix formula with bottled water? _____ Tap water? _____

Daily juice intake: _____ oz/day

Daily water intake: _____ oz/day

Do you use well water? Yes No

Do you use bottled water? Yes No

Daily pop/soda intake: _____ oz/day

Does the child eat/drink between meals and snacks? Yes No

Please list foods the children particularly like, or are easy for him/her to handle:

Please list foods the child particularly dislikes, or cannot eat well. Describe why they are difficult for your child. _____

Have you offered these foods at least 10-15 different times to the child? Yes No

Positions and Equipment for Feeding:

What position do you typically use for feeding the child (check all that apply)?

Sitting on your lap Reclined in your arms High Chair Booster Seat Adapted Chair

Other: _____

Are there any adaptations used to help the child maintain a correct sitting position? Yes No

(Check all that apply)

Bolster Seat Insert Chest Strap Lap Tray Head Support Hip Strap

Other: _____

Can the child do any of the following? (check all that apply)

Hold head up? Since age: _____

Roll? Since age: _____

Crawl? Since age: _____

Sit alone? Since age: _____

Pull to standing position? Since age: _____

Cruise furniture? Since age: _____

Walk independently? Since age: _____

Do you use any special utensils for feeding your child? Yes No

Latex Covered Spoon Special Nipple Training Cup Cut-out Cup

Other: _____

Do you let the child get messy with foods while they are eating? Yes No

If yes, does the child enjoy this or fuss with being messy? Enjoys Fusses

Comments: _____

Do you as the parent/guardian; have trouble letting your child get messy with foods? Yes No

Do you brush your child's teeth? Yes No How many times per day? _____

Do you have any problems brushing the child's teeth? Yes No N/A

If yes, please explain: _____

Check any you use to clean teeth: Water Washcloth Toothbrush Infadent

Baby (non-fluoride) Toothpaste Fluoride Toothpaste

If the child is over 3 years, have they been to the dentist? Yes No

Does the child show any negative response to his/her face being touched or washed? Yes No
If yes, please describe: _____

How would you describe the child's personality? _____

Does the child bring toys or hands to his/her mouth? Yes No

Does the child suck on his/her pacifier? Yes No

Does the child feed himself/herself? Yes No

Which hand does the child use? Right Left Both

Does the child like to be: (check all that apply)

Touched Cuddled Rocked Swung

Do you have any concerns about the child's sleeping pattern? Yes No

If yes, please describe: _____

Other Questions:

If there are questions regarding the child's feeding, breathing, or speech development, please list them here so that we can be sure to discuss them with you. _____

What are your expectations of the Feeding Clinic? What do you hope that the child will come away with after the evaluation? _____

On a scale of 1 to 10 (1 being the least stressed and 10 being the most stressed), how would you rate your stress in relationship to the child's feeding difficulties? (Please circle the appropriate number)

(least stressed) 1.....2.....3.....4.....5.....6.....7.....8.....9.....10 (most stressed)

