Children's MINNESOTA

FEEDING CLINIC QUESTIONNAIRE

Date form completed: _____

Child's Name: _____ DOB: ____/_____/_____Age:_____
Address & City_____
Phone: Home: ( ) _____Cell: ( ) _____
Child Lives: Home: _____ Foster home: _____ Other: _____

Parent's Name: _____
Address (if different this child's) _____
Phone: Home ( ) _____ Cell: ( ) _____Work: ( ) _____
Email: _____
Occupation: _____

Parent's Name: _____
Address (if different this 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 this child's care, including GI specialists:
Phone: ( ) _____
Phone: ( )_____
Phone: ( )_____
Phone: ( )_____

* F E E D I N G C L *

PLACE PATIENT LABEL HERE

FEEDING CLINIC QUESTIONNAIRE

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, etc)

_____
_____
_____
_____

Was this 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 this child has had: _____
_____
_____

Please list all persons living in the home and their ages: _____
_____
_____
_____

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

PLACE PATIENT LABEL HERE

FEEDING CLINIC QUESTIONNAIRE

Has this 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 this 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 this child vomiting? ❑ Yes ❑ No if yes, how frequently, times of day, with feeding, after feeding etc. _____
_____

Has this 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 this 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 this child have any hearing difficulty? ❑ Yes ❑ No If so, please describe _____
_____
Does this child seem overly sensitive to sounds? ❑ Yes ❑ No

PLACE PATIENT LABEL HERE

FEEDING CLINIC QUESTIONNAIRE

Therapeutic History:

Does this child receive **Speech-Language Therapy**? ❑ Yes ❑ No
Where: _____ How often: _____
Program Emphasis: _____
Therapist: _____
Address: _____

Does this child receive **Occupational Therapy**? ❑ Yes ❑ No
Where: _____ How often: _____
Program Emphasis: _____
Therapist:_____
Address:_____

Does this child receive **Physical Therapy**? ❑ Yes ❑ No
Where: _____ How often: _____
Program Emphasis: _____
Therapist: _____
Address: _____

Education:

Does this child currently attend school or receive other school services (such as ECSE teacher, B-3 program, County program, Vision Therapist etc)? ❑ 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 this child had an evaluation by a Psychologist? ❑ Yes ❑ No
If so, Where? _____Frequency: _____
Therapist: _____ Phone: _____

Are you having any problems managing this 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 this child's behavior at home or school?_____
_____
_____

Nutrition and Feeding

Current weight: _____ Height: _____ Date: _____
Does this child have difficulty gaining weight? ❑ Yes ❑ No
Have there been past or present nutritional concerns? ❑ Yes ❑ No

PLACE PATIENT LABEL HERE

FEEDING CLINIC QUESTIONNAIRE

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

Does this 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 this 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 this 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 this child eat/drink between meals and snacks? ❑ Yes ❑ No
Please list foods this child particularly likes or are easy for him/her to handle:
_____
_____
_____
_____

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

PLACE PATIENT LABEL HERE

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

Positions and Equipment for Feeding:

What position do you typically use for feeding this 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 this 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 this 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 this child? ❑ Yes ❑ No
❑ Latex Covered Spoon ❑ Special Nipple ❑ Training Cup ❑ Cut-out Cup
Other: _____

Do you let this child get messy with foods while they are eating? ❑ Yes ❑ No
If yes, does this child enjoy this or fuss with being messy? ❑ Enjoys ❑ Fusses
Comments:_____
_____

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

Do you brush this child's teeth? ❑ Yes ❑ No How many times per day? _____
Do you have any problems brushing this 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 this child is over 3 years, have they been to the dentist? ❑ Yes ❑ No

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

PLACE PATIENT LABEL HERE

How would you describe this child's personality? _____
_____
_____
_____

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

Does this child suck on his/her pacifier? ❑ Yes ❑ No

Does this child feed himself/herself? ❑ Yes ❑ No

Which hand does this child use? ❑ Right ❑ Left ❑ Both

Does this child like to be: (check all that apply)
❑ Touched ❑ Cuddled ❑ Rocked ❑ Swung

Do you have any concerns about this child's sleeping pattern? ❑ Yes ❑ No
If yes, please describe: _____
_____
_____

Other Questions:

If there are questions regarding this 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 this 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 this child's feeding difficulties? (Please circle the appropriate number)

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

PLACE PATIENT LABEL HERE