TORRANCE MEMORIAL MEDICAL CENTER

Occupational Therapy Feeding Questionnaire:

Please fill this questionnaire out prior to your child's feeding evaluation. This information will assist the therapist with assessing your child's abilities and areas of difficulty with feeding. If you can not answer any of the following questions, please leave it blank and ask your feeding therapist.

Child's Name:_____ **Date of Birth**:_____

Medications: _____

Allergies:_____

Recent Medical Tests / Studies Performed:

_____

_____

Primary reason you are seeking a feeding evaluation:

_____

_____

Birth / Health History:

1. Was your child born full –term or prematurely? If premature, how many weeks early were they born?

2. Vaginal or Cesarean birth?

3. Complications during pregnancy / labor / delivery / post- natally?

4. Any recent hospitalizations? If yes, please list dates and reason for hospitalization.

5. Please list any gastroenterologists or other specialty doctors that your child has seen or is seeing:

6. Any history of being diagnosed with reflux, pneumonia's or upper respiratory illnesses?

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7. Have you ever suspected your child may have reflux? If so, why?

8. Has your child ever had a video-swallow study performed? If yes please list the date, location and results.

9. Developmental milestones:

    1. Sat at: _____months
    2. Crawled at: _____months
    3. Walked at: _____months

Feeding History and Status:

1. <u>Feeding milestones (please fill out if relevant, if not just put NA):</u>

    a. Was / Is your child breast and/or bottle fed?_____
        i. Did you have difficulty with breastfeeding? If so, did you receive any lactation assistance?

    b. When did you start giving your child a bottle? _____
        i. Were there any difficulties with bottle feeding?

    c. When did you start introducing "stage-1" purees / baby cereals?_____
        i. What was your child's reaction to being fed puree (i.e. wouldn't open their mouth, spit food out, coughed, stuck tongue out, etc.)?

    d. When did you start introducing thicker purees such as stage-2 foods?_____
        i. What was your child's reaction? When did your child eat this texture without difficulty?

e. When did you start feeding your child baby crackers?_____
    i. What was their response to the crackers? Did they demonstrate a bite or chewing motion or did they just suck and dissolve the crackers?

f. When did you start to introduce soft lumpy foods, or soft mixed texture foods such as stage-3 foods or coarsely mashed table foods?_____
    i. What foods have you tried with this consistency and what was the outcome (i.e. your child spit it out, coughed, choked, handled it fine, most came out of their mouth, etc.)?

g. When did you start feeding your child foods such as pastas, bread, mac-n-cheese, and/or soft chopped table foods such as steamed vegetables?_____
    i. What was the response?

    ii. When was your child able to eat this texture with a clear chewing motion and no difficulty swallowing?

h. When did you start feeding your child higher mixed texture foods (such as rice with steamed veggies, etc) or meats such as chicken or steak?_____
    i. What was the response?

    ii. When was your child able to eat this texture with a clear chewing motion and no difficulty swallowing?

i. When did you introduce the Sippy cup?_____
When did you introduce the straw cup?
When did you introduce the open cup?

    i. What types of cups does your child use / prefer now and what will they drink from them (water, milk, juice, etc)?

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2. Please provide a detailed description of your child's **Typical** daily meal schedule:

	Time	Meal **(specify foods and amount given):**	Liquids **(specify amount given)**	How long to complete meal / drink
Breakfast:				
Lunch:				
Dinner:				

3. What are some flavors / textures that your child enjoys? (list **everything** he/she is willing to eat on a regular basis):

4. What are some flavors that your child dislikes? (i.e. do any particular flavors or textures seem to stand out as ones he/she won't eat)?

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5. Does your child gag / vomit during feedings? What triggers the gag response?

6. Does your child demonstrate other sensory aversions such as disliking certain textures of clothing, touching certain objects, objecting to hair or nails being cut, or walking with bare feed?

7. Does your child demonstrate decreased awareness of food on his/her face and/or excessively drool?

Self-Feeding Status:
(Please answer the following questions if applicable for your child's age)

1. Does your child independently finger feed?

2. Does child self-feed independently using a spoon or fork?

3. Where does your child eat? Highchair, booster seat, in your lap, child sized table, adult sized table?

4. Does your child verbally request food? If not, how do they indicate when they are hungry?

5. **Has your child had any previous feeding evaluations or received occupational therapy services elsewhere?**

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Non-Oral Feeders:
Please fill out this section only if you child is tube fed.

1. Does your child have a G or J Tube?

2. When was the tube placed?

3. Is your child fed with bolus or continuous drip feeds? What is the amount and frequency of feeds?

4. Is your child cleared to take any oral feeds? If so what textures are they cleared for?

5. Do you have an oral stimulation program for your child?

6. Any recent complications with the tube?

Thank you for taking the time to fill out this questionnaire prior to your child's evaluation. This will facilitate the evaluation process so that we can use your 50 minute evaluation time slot effectively. If you have any questions prior to evaluation please call us at (310 325-9110 X 6989 or if you need to reschedule please call (310) 325-9110 X 2073.

Thank You,

Marita Kakuk, OTR/L, SWC

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