#

# Occupational Therapy FEEDING Pre-Exam Questionnaire

*In order to evaluate your child’s condition fully, please be as accurate as possible. Thank you.*

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Current Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Growth Chart Percentile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was/is your child breast fed? **[ ]**  Yes **[ ]**  No

Was/is your child bottle fed? **[ ]**  Yes **[ ]**  No

Drinks from: bottle breast sippie cup straw open cup

Utensils used: fork spoon finger fed caregiver assist

Special Diet: **[ ]**  Yes **[ ]**  No

Shows signs of hunger: **[ ]**  Yes **[ ]**  No

Food texture preferences - crunchy, smooth, warm, cold

Feeding environment High Chair\_\_\_ Table\_\_\_ Walks Around\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_

How long does your child sit for a meal?

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
|  Over-stuffing mouth with food |  |  |
| Gags/vomits during feedings |  |  |
| Frequently drools  |  |  |
|  Messy eater |  |  |
| Strong food preferences |  |  |
| Picky eater  |  |  |
|  Avoids face washing |  |  |
|  Avoids tooth brushing |  |  |
|  Not chewing food  |  |  |
| Spillage of food/drinks from their mouth |  |  |
|  Avoids being messy |  |  |
|  Pocketing |  |  |
| Grazes |  |  |
|  Throws food |  |  |
| Difficulties using cup and/or straw |  |  |
| Mouths objects/fingers |  |  |

**History of or concerns with:**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Reflux |  |  |
| Vomiting |  |  |
| Constipation |  |  |
| Diarrhea |  |  |
| Slow Gastric Emptying |  |  |
| Failure to Thrive |  |  |

Food likes (please list)

Food dislikes (please list)

Childs feeding schedule:

1. What are your primary concerns and the primary problems? Are you concerned about your child’s safety while eating? Please describe:
2. 7. On the scale below circle your level of concern for your child:

## Mild Moderate Severe

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

1. How often do you experience these problems with your child? Constantly Daily Weekly
2. Are any of your family’s everyday activities affected? **[ ]**  Yes **[ ]**  No
	* If yes, describe how.
3. What do you think has caused this problem?
4. Approximately when did it start?\_\_\_\_\_\_\_\_\_\_\_ Is it getting worse, better, or staying the same?
5. Has your child had these problems before? **[ ]**  Yes **[ ]**  No