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?

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:

	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		

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 <u>circle</u> your level of concern for your child:

   Mild *Moderate* *Severe*
   0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

3. How often do you experience these problems with your child? Constantly Daily Weekly

4. Are any of your family's everyday activities affected? ☐ Yes ☐ No
   - If yes, describe how.

5. What do you think has caused this problem?

6. Approximately when did it start?_____ Is it getting worse, better, or staying the same?

7. Has your child had these problems before? ☐ Yes ☐ No