



# CREATIVE SPEECH SOLUTIONS, LLC

*Pediatric Therapy Center*

## FEEDING QUESTIONNAIRE

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Person(s) providing the information: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Date: \_\_\_\_\_

### FEEDING HISTORY/BEHAVIORS:

Do you feel your child has feeding issues? How serious do you feel they are? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How would you describe your child's challenges surrounding eating, chewing, etc? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did you first notice that your child had a feeding problem? What were the initial symptoms? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are ways in which you have tried to help your child with his/her feeding issues? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have a history of constipation, diarrhea, gas, or reflux? If yes, please explain

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child has any recent weight gain or loss in the last 6 months? If yes, please explain

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Is your child taking any vitamins/minerals, herbal or nutritional supplements? \_\_\_\_\_  
If yes, please list with dosage (mg/day) \_\_\_\_\_

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Is your child currently following a specific diet? (e.g., gluten free, casein free, low fat, ketogenic, soy free, etc.)? If yes, please explain. \_\_\_\_\_

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Is your child adverse to certain smells or textures? Explain. \_\_\_\_\_

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Will your child taste new foods? If not, what does he/she do when presented with a new food?

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What is your child's reaction to foods he/she does not like? \_\_\_\_\_

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What help, if any, have you had in managing your child's problems with eating? Explain. \_\_\_\_\_

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Does there seem to be a behavioral problem associated with eating? If yes, how so? \_\_\_\_\_

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How do you handle undesirable behaviors that arise during mealtimes? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child finger-feed? What kinds of food? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child still taking the bottle or breast? If yes, how often? \_\_\_\_\_  
\_\_\_\_\_

Does your child drink from an open cup/straw cup/sippy cup? How many times per day is the cup used? Which type of cup is used most often? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child sit down for two - three meals or does he/she graze throughout the day?  
\_\_\_\_\_  
\_\_\_\_\_

**TIME REQUIRED TO COMPLETE A MEAL**

How long does it take for your child to complete a meal in total? \_\_\_\_\_

How long (approximately) is spent during mealtime:

Eating: \_\_\_\_\_

Drinking: \_\_\_\_\_

Playing with food/ fidgeting: \_\_\_\_\_

Avoiding/ protesting: \_\_\_\_\_

Other (describe): \_\_\_\_\_  
\_\_\_\_\_

**TYPES OF FOODS CONSUMED**

List foods that your child particularly likes. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List foods that your child particularly dislikes. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are there objections to hot or cold foods? Describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child particularly like/dislike sour or spicy foods? Describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What kinds of foods are easiest for your child to eat? Give examples.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What kinds of foods are hardest for your child to eat? Give examples.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In what way are they easy or difficult?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3 DAY FOOD RECORD:** To the best of your ability, please record your child's food and beverage intake for 3 days. Please be as specific as possible and list portion sizes (e.g.,  $\frac{1}{2}$  cup blueberry yogurt; 4 oz apple juice). Please be sure to list all snacks and treats as well (e.g., 10 skittles; 5 crackers).

**Day 1:**

Breakfast \_\_\_\_\_  
\_\_\_\_\_

Lunch \_\_\_\_\_  
\_\_\_\_\_

Dinner \_\_\_\_\_  
\_\_\_\_\_

Snacks \_\_\_\_\_  
\_\_\_\_\_

**Day 2:**

Breakfast \_\_\_\_\_  
\_\_\_\_\_

Lunch \_\_\_\_\_  
\_\_\_\_\_

Dinner \_\_\_\_\_  
\_\_\_\_\_

Snacks \_\_\_\_\_  
\_\_\_\_\_

**Day 3:**

Breakfast \_\_\_\_\_  
\_\_\_\_\_

Lunch \_\_\_\_\_  
\_\_\_\_\_

Dinner \_\_\_\_\_  
\_\_\_\_\_

Snacks \_\_\_\_\_  
\_\_\_\_\_