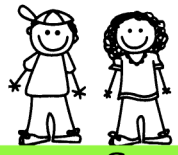

CREATIVE SPEECH SOLUTIONS, LLC

Pediatric Therapy Center

FEEDING QUESTIONNAIRE

Child's Name_____ Age_____

Informant_____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. _____

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

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

Is your child adverse to certain smells or textures? If yes, please explain.

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

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

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

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

How do you handle undesirable behaviors that arise during mealtimes?

Does your child finger-feed? If yes, 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? If yes, how many times per day is the cup used and 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? If yes, describe. _____

_____

_____

Does your child particularly like/dislike sour or spicy foods? If yes, 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., 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 _____

_____