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Child's Name: _____Date of Birth:_____
Parent's Name (s):_____Phone:_____
Home Address:_____
Email address:_____
Child's school:_____Grade:_____
Doctor's Name: _____Phone:_____

REASON FOR REFERRAL:
Who referred you?_____
What are your main concerns about your child's feeding skills?
_____
When did you first become concerned with your child's feeding skills?
_____

MEDICAL HISTORY:
Were there any problems during your pregnancy? Yes / No
Were there any problems during your child's birth? Yes / No
Has your child had any significant illnesses, injuries, and/or hospitalizations? Yes / No
If yes to any of the above, please describe: _____
_____
List any medications currently being taken: _____
Does your child have any allergies (medicine, food, environment)? Yes / No
If yes, please list: _____
Has your child been evaluated by an ear, nose and throat (ENT) doctor? Yes / No
If yes, why: _____
Does your child have a history of frequent ear infections? Yes / No
If yes, please describe:
_____
Does your child have ear (PE) tubes? Yes / No, If yes, what date?_____
Has your child's hearing been tested? Yes / No
If yes, when: _____ where (school, clinic, etc): _____
Results: _____
Does your child have any sleeping difficulties / snoring?_____

Feeding:
Was your child bottle or breastfed? _____
Did your child have any difficulty?_____
If your child is still being bottle fed, how many ounces a day is he/she drinking?_____
_____

If your child is eating solid food, please fill out this chart as best you can.

	Age:	Response:
Pureed food		
Soft (cooked) fruits / veggies		
Soft chewable foods (egg, bread, pasta)		
Open cup		
Straw		

Food history?

Used to	Sometimes	Always

Please provide an example of the quantity of food that your child will eat during a meal:
For example: 1/2 cup pasta and 2 meatballs, a 6 oz yogurt, a half a banana.
_____
_____

Does your child demonstrate difficulty chewing any foods? Explain:
_____

Does your child gag or has your child ever choked during mealtime? Explain:
_____

Does your child to display any negative behavior during meal time such as throwing food, crying or pushing away the spoon? Explain:_____
_____

Does the child is better for one adult person of another adult, i.e. babysitter, grandparent?_____

Does the child eats better during a particular time of the day? If so, when?
_____

How much does your child weigh? _____
Has your child always gained weight at regular intervals? If not, provide more details
_____

Does your child know how to drink from an open cup and straw? _____
Does your child drink from a bottle or sippy cup? If not, what age did he/she stop?
_____

What is your child ever diagnosed with reflux? _____
If yes, please answer the following questions:
Was medication prescribed? _____ If so which one? And how long has your child been on the medication? _____
Did you see any changes from the medication? _____

Does the child have regular bowel movements?
_____
Does the child burp a lot?_____

Has your child ever receive a feeding evaluation? If so, by whom and when? _____
_____
Has your child ever received feeding therapy? If so, by whom and when? _____
_____
Does your child receive any therapy such as physical or occupational? _____

Other Feeding/Oral motor History: check all that apply (past and present behavior)

____Thumb/finger sucking
____Pacifier use
____Excessive drinking while eating
____Any drooling
____Tongue Thrust
____Tongue Tie
____Teeth clenching/grinding (circle)
____Sensitive gag reflex
____Doesn't like his/her teeth brushed
____Mouth breathing
____Pulls lips in to clean them (not lick)
____Bites rather than licks ice cream

If you checked off any of the above, please describe the problem in greater detail:

_____
_____
_____

Developmental / Speech and Language History:
Approximately what age did your child reach the following milestones:

_____Sat alone ____Crawled
_____Walked
_____Babbled ____Said first word (s)
_____Put two words together ____Spoke in short sentences

Please keep a detailed feeding log for one week and email it to me before the assessment Write down the time, type of food and amount of food the child eats. When I receive this log I will tell you what foods to prepare for the assessment.

Please return this questionnaire and feeding log to: dinaezslp@gmail.com