



2021 PARENT/CAREGIVER QUESTIONNAIRE + FEEDING

Date: _____

GENERAL INFORMATION

Child's Name: _____

Age: _____

Date of Birth: _____

Sex: _____

Parent 1's Occupation: _____ Level of Education: _____

Parent 2's Occupation: _____ Level of Education: _____

PATIENT HISTORY

Why is your child here today?

When was the problem first noticed? _____

Is your child aware of the problem? Yes No

If yes, how does your child feel about it? _____

How would you describe your child? _____

FAMILY INFORMATION

List all people in household:

Name	Age	Sex	Grade	Relation

Does anyone else in the family have speech, language, or hearing problems?

Yes No

If yes, please describe: _____

What language(s) does your child speak? _____

HEALTH & MEDICAL HISTORY

Has your child ever been examined by any other professionals?

Yes

No

	Doctor	Practice	Date	Diagnosis Given/Results Found
Neurologist				
ENT				
GI				
Developmental Pediatrician				
Pediatrician				
Other				

Is your child currently on any medications?

Yes

No

Medication	Dosage	Frequency	Purpose

Please describe your child's general health: _____

Please list any health conditions, surgeries, etc. of note: _____

Has your child had his/her tonsils and adenoids removed?

Yes

No

Has your child had any ear trouble (earaches, infections)?

Yes

No

How many? _____

Has your child's hearing been tested?

Yes

No

If yes, when? Results? _____

Has your child ever had (PE) tubes inserted?

Yes

No

If yes, when? _____

Has your child's vision been tested?

Yes

No

Has your child ever worn glasses?

Yes

No

Does your child currently wear glasses?	Yes	No
Does your child have dental problems?	Yes	No
Has your child had any seizures?	Yes	No
If so, are these treated with medication?	Yes	No

 If yes, please list: _____

Were there any noticeable changes in your child's general behavior or speech after a certain life event, illness, surgery, etc.?

	Yes	No
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 If so, explain: _____

Does your child have any known skin allergies?	Yes	No
Latex allergy?	Yes	No

Does your child have any **food** allergies or is s/he on a restricted diet? If so, please explain:

BIRTH HISTORY

Is the child adopted?	Yes	No
At what age? _____		

Does your child know they are adopted?	Yes	No
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Were there any complications or illnesses that occurred during pregnancy?

Yes	No
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 If so, please explain: _____

Was any medication taken during pregnancy?	Yes	No
--	-----	----

 If yes, please list: _____

Weight at birth _____	Was s/he full-term?	Yes	No
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Type of Birth:	Normal	Induced
	Forceps	Caesarean
	Premature (at ____ weeks)	

Any specific problems/issues at birth?	Yes	No
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 If yes, list: _____

How would you describe your child's 1st year? _____

DEVELOPMENTAL HISTORY

Were developmental milestones met on time? Yes No

Which milestones were met on time?

Sits unsupported	Walks
Eats solid foods	Self-feeds
Crawls	Self-feeds
Stands alone	Bladder/bowel trained
Babble	Use 2 word combos
Say 1 st word	Say Complete sentences

If milestones were delayed, please elaborate: _____

Does your child show aversive reaction to touching certain objects or textures? (Check all that apply).

on hands	on feet
on mouth/lips	on body
on face	inside mouth
toothbrush	hair brush

When did teeth erupt? _____

Last visit to dentist? _____

Does your child exhibit bruxism? Yes No

Does your child exhibit thumb sucking? Yes No

Does your child use a pacifier? Yes No

If yes, please describe usage: _____

When did you discontinue pacifier usage? _____

SPEECH & LANGUAGE HISTORY

How does your child communicate? (check all that apply)

Eye contact	Moves person/adult
Gestures	Vocalizations
Jargon	Sign Language
PECS symbols	AAC device
Words	Phrases
Sentences	Conversation
Writing	Other: _____

What efforts does your child make to communicate his/her wants when not understood?

Is your child's speech understandable to: family? friends? strangers?

Did speech learning ever seem to stop for a period? Yes No

If so, describe: _____

Can your child follow directions? Yes No

1 step direction

2 steps

3 steps

Please rate your child's attention: **Good** **Fair** **Poor**

Preferred tasks

Non Preferred tasks

Academic tasks

During interactions with others

What have you done to help your child's speech and language?

FEEDING DEVELOPMENT/HISTORY

Were there any feeding problems in early life? Yes No

If so, describe: _____

Are there any present eating problems? Yes No

If so, describe: _____

Does s/he have difficulty chewing or swallowing? Yes No

Does s/he drool? Yes No

Is your child a picky eater? Yes No

How many food items are in your child's diet? <5 5-10 10-20 20+

What are your child's favorite foods? _____

Is there anything your child refuses to eat? _____

Does your child use utensils? Yes No

Do they feed themselves? Yes No

If not, who feeds the child: _____

How does your child take in liquid?	Syringe	Bottle
	Sippy cup (soft spout)	Sippy cup (hard spout)
	Straw cup	Open cup
	360 cup	

Additional Comments on Feeding: _____

Are mealtimes difficult?	Yes	No
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Will she/he try new foods?	Yes	No
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Has your child ever had issues with:	Reflux	Constipation
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If yes, when? _____

Current weight: _____	Height: _____
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Does your child have a history of respiratory infections?	Yes	No
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Does your child have a history of recurring pneumonia?	Yes	No
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Has your child ever been by physician for feeding concerns/difficulties?

Yes	No
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If yes, list physician and date(s): _____

Has your child ever had a swallow study performed?	Yes	No
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If yes, when and what were the results? _____

Does your child receive supplemental tube or oral feeding (i.e. Pediasure)?

Yes	No
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If yes, please complete the following:

Amount: _____

Frequency: _____

Rate: _____

Method:

NG

PEG

GEG

Bolus

Oral

Please describe the seating/positioning your child is in when she/he eats at home:

High chair	Held on lap	Floor
Wheelchair	Booster seat	Feeder seat
Upright	Regular chair	Semi-upright
Reclined	Child roams while eating	

Other: _____

Child will eat for:	Mom	Dad	Grandparent
	Nanny	School	Other: _____

Independence of feeding:

Child feeds self

Child is fed by (list all): _____

Feeding equipment /utensils used (check all that apply):

Bottle	Nuby cup	Sippy cup
Open cup	Straw	Baby spoon
Toddler fork/spoon	Teaspoon	Standard size spoon
Fork	Adapted utensils	Scoop bowl/plate

Type of bottle, cup, etc.: _____

Other: _____

List the food/liquid consistencies that your child eats (check all that apply):

Regular/thin liquids	Textured purees	Mashed foods
Nectar thick liquids	Smooth purees	Minced/ground
Honey thick liquids	Regular table foods	Chopped foods
Baby cereals/food		

Stage One

Stage Two

Stage Three

Appetite

Does your child have a limited diet?	Yes	No
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Does your child eat the same foods daily?	Yes	No
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Special diet:

Gluten Free

Dairy/Casein Free

Vegetarian

Vegan

Kosher

No Sugar

Other: _____

Please list foods typically served and amount eaten, where applicable.	Amount/Types of Food	Time to finish meal
Breakfast		
Snack 1		
Lunch		
Snack 2		
Dinner		
Snack 3/Dessert		

Check ALL foods/liquids your child currently eats.

Texture

crunchy

crispy

smooth

lumpy

hard

chewy

mixed consistencies

uniform lumpy (cottage cheese

Taste

salty

sweet

spicy

tart

flavored

bland

Temperature

hot

warm

cold

cool

Breads

Crackers

Chips

Flour tortillas

Pretzels

Cheese puffs

Pizza crusts

Bagels

Biscuits

Cinnamon rolls

Cornbread

Pies

Pop tarts

Bread:	white	wheat	rye	gluten free	French
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Taco Shells

Hamburger/hot dog buns

Texas toast/garlic bread

Rolls

Hot rolls, baked bread, croissants

Muffins

Doughnuts

Banana/apple/pumpkin bread

Cupcakes

Cake

Pastries

Meats

Baked chicken

Chicken strips

Turkey

Fish (fried)

Tuna salad

Roast

Steak

Veal

Bacon

Meatballs

Lil smokies

Fried chicken

Chicken nuggets

Hot Dogs

Fish (baked or broiled)

Beef

Hamburger

Ham

Pork

Sausage

Baby food meat sticks

Nuts

Peanut butter

Peanuts

Almonds

Almond Butter

Nutella

Cashews

Pecans

Walnuts

Sun Butter

Other: _____

Potato Products

French fries	Tater tots
Tater rounds	Hash browns
Baked potatoes	Potato chips
Potato wedges	Mashed potatoes
Baked sweet potatoes	Candied sweet potatoes
Sweet potato chips	Scalloped/Au Gratin Potatoes
Veggie Fries	

Condiments

Ketchup	Mayo
Miracle whip	Mustard
Dijon/Spicy mustard	Honey mustard
BBQ sauce	Chili sauce
Ranch dressing	Butter/Margarine
Honey	Syrup
Cool Whip/Whipped Cream	Cheese Dip
Salsa	Guacamole
Hummus	

Breakfast Foods

Oatmeal	Cream of Wheat
Pop Tarts	Dry cereal
Pancakes	Cereal w/Milk
Waffles	French toast
Yogurt	Fried Eggs
Scrambled eggs	Omelet
w/cheese	w/cheese
w/veggies	w/veggies
w/meat	w/meat
Hard Boiled eggs	Poached eggs
Go-Gurt	Fresh fruit
Bacon	Sausage
Ham	Grits

Oatmeal Bites
Breakfast shakes
Cinnamon raisin bread
Granola bars

Toast: w/butter
w/jelly
w/peanut butter

Other: _____

Vegetables

Green beans
Cauliflower
Squash
Zucchini
Carrots
Cabbage
Asparagus
Brussel sprouts

Broccoli
Corn
Cucumber
Spinach
Lettuce
Avocado
Mushrooms
Onion

Peppers: Bell red yellow

Peas: English black eyed

Beans: black kidney pinto

white garbanzo

Fruits (circle specifics)

Apple: red green yellow

Banana

Blueberry

Cantaloupe/Honey Dew

Cherry

Grapes

Kiwi

Lemon

Lime

Orange

Pears

Pumpkin

Watermelon

Pineapple

Raspberry

Mango

Strawberry

Tangerine/Clementine

Tomato

Dried Fruits

Cherries

Raisins

Blueberries

Oranges

Bananas

Soups

Cheese

Stew

Egg drop

Chicken noodle

Cheese & Broccoli

Miso

Chili

Vegetable

Beef noodle

Chicken & Rice

Cheese & Vegetables

Plain Broth

Pasta/Rice

Brown Rice

Quinoa

Pasta: Penne

Spaghetti

Elbow

White Rice

Mac N Cheese

Sauce: Red Sauce

Alfredo

Pesto

Combination Foods

Spaghetti w/meat balls/sauce

Baked Ziti

Casseroles: _____

Lasagna

Pizza (list toppings) _____

Cheese

Cheddar

Parmesan

Monterey jack

Cottage cheese

Sour Cream

Shredded

American

Swiss

Colby

String cheese

Cream Cheese

Sliced

Liquids

Water

Milk (whole, 2%, skim)

Soda

Unsweetened tea

Floats

Caloric supplements: _____

Flavored milk

Tea

Sweet tea

Milk shakes

Drinkable yogurt

Protein/M meal Replacement Shakes

Juice

Apple

Orange

Berry

Grape

Fruit punch

White grape

Pear

Prune

Strawberry

Kiwi

Cranberry

Comments:

Please check the characteristics that your child exhibits during meals:

OBSERVATIONS	FOODS	LIQUIDS
Coughing		
Gagging		
Vomiting		
Choking		
Eyes watering		
Changes in breathing		
Change in color of face(becomes, red, pale, etc.)		
Food comes out of nose		
Fatigue/falls asleep		
Head thrown back when eating/swallowing		
Spillage food without chewing		
Swallows food without chewing		
Takes very large bites		
Excessive time to manipulate bites		
Nibbles on food		

OBSERVATION	FOODS	LIQUIDS
Overstuffing		
Storing/holding in mouth (time: _____)		
Requires support at chin/lips/jaw for closure/swallow		
Pushes food /utensil away		
Pushes adult away		
Crying		
Hitting		
Kicking		
Screaming		
Self-injurious behaviors		
Throwing food/utensils/tray		
Spitting		
Prompt dependent to take bites		
Plays with food		
Increased stress/anxiety levels		

EDUCATIONAL HISTORY

Child's current school: _____

Please list all previous schools and years attended: _____

Current grade: _____

Has your child repeated a grade? Yes No

If yes, which grade? _____

Indicate performance level in school: Below Average Average Above Average

Did your child attend nursery school and/or pre-K? Yes No

If yes, where? _____

Does your child like school? Yes No

Does your child receive services through any of the following:

EIP Tutoring
IEP 504 plan

If yes, please list services and frequency: _____

THERAPY:

Please provide information on therapies your child currently receives.

Therapy	Frequency	Therapist Name/Practice
Speech		
Feeding		
Occupational		
Physical		
ABA		
Floor Time		
Music		
Nutrition		
Other		

BEHAVIOR/SOCIAL:

Does your child play: Alone with older children
with peers with younger children

Does your child have close friends? Yes No

What are your child's most frequent discipline problems? _____

Who handles discipline? _____

How is the child disciplined? _____

Please list your child's strengths when interacting with peers: _____

Please list concerns you have about your child's interactions with peers: _____

OTHER COMMENTS:
