Cheshire Fitness Zone and Pediatric Therapy

328 Main Street

Cheshire, CT

203-250-9663

(6 and over)

Patient:

Date of Birth:

Date:

*****Please take the time to complete this survey by providing as much detailed information as possible. It would also be helpful to share a video with your therapist during the initial evaluation of a typical feeding session at home.**

1) Does your child have an existing developmental or medical condition? If yes, please describe

   _____

   _____

2) Does your child have allergies or diet restrictions? If yes, please describe

   _____

   _____

3) Has your child had a swallow study completed? If yes, where was it completed? Please describe results

   _____

   _____

4) Do you have concerns regarding your child's ability to swallow? If yes, please describe

   _____

   _____

5) Is there a history of or is your child currently tube fed? If yes, please describe

   _____

   _____

Patient: Date:

6) Has your child experienced episodes of gagging or choking? If yes, please describe a typical unpleasant experience and how often this occurs. Please indicate if hospitalization or medical attention was required.

_____

_____

7) What routines are helpful for getting your child to eat meals? Please check all that apply

rewards__ __preferred foods____ sticker chart__ __exercise before__ __specific utensils____
use of electronics including television, iPad etc.____ use of a visual/picture schedule ____

8) What changes to your child's food or liquids have you made at meal time to improve your child's meal time success? Check all that apply and please add any specific information that may be helpful .

Change food texture : soft foods only____ smooth textures only ____
Change size or shape of food pieces: ____
Change temperature by serving food cold____
Enhance taste by adding spices or salt____
serve bland food only___
Thicken liquids or make water or milk available to wash down food____

9). What food or drinks are most difficult for your child?

_____

_____

10). What behaviors does your child demonstrate when refusing to eat a new food or non-preferred food?

_____

_____

Patient: Date:

For children 6 years and older

**** Please check off all that apply now or in the past. If the past, how old was your child?**

__ constantly wiping face at meal time
__food all over face
__only closes lips when cued
__only chews on one side
__loses control of liquid
__coughing during or shortly after eating
__sounds congested after eating
__grinding of teeth
__avoids touching different foods or textures
__avoids certain flavors or spices
__easily distracted when eating
__stuffs food in mouth
__puffs cheeks when drinking liquids
__bothered by light touch to face or body
__intolerant of food on hands
__improvements in eating with background noise
__mouths objects
__bites or chews objects or clothing frequently
__sensitive to itchy clothing
__sensitive to excessive movement
__sensitive to loud noises
__shows strong preferences for soft food
__shows strong preference for crunchy food
__shows strong preference for chewy food
__shows strong preference for a certain colored food
__avoids mixed textured food

*****Please fill out the 3 day food diary attached.**