****Please return The Feeding Questionnaire & Food Diary to schedule a Feeding evaluation.**

Feeding Questionnaire (6 yrs old and under)

Patient name:_____

Date of Birth:_____

Today's Date:_____

***Please 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? 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
   _____
   _____

6) 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
   - ☐ Small meals/snacks offered throughout the day
   - ☐ Other (if other please describe) _____

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For children Birth to One

**Please check off all that apply

- ☐ My child experienced difficulty latching on to the breast or bottle
- ☐ I hear "gulpy" sounds when my child is drinking
- ☐ My child turns his/her head often while being fed
- ☐ My child cries often while being fed
- ☐ My child has coughing spells and or color changes while feeding
- ☐ Excessive liquid spills from my child's mouth while eating/drinking
- ☐ My child falls asleep often during feeding
- ☐ Concerns regarding height and/or weight
- ☐ Other (if other please describe) _____

For children 1 year and older

**Please check off all that apply and circle where indicated.

- ☐ My child has coughing spells and or color changes while eating
- ☐ Excessive liquid spills from my child's mouth while eating/drinking
- ☐ My child frequently gags, chokes or coughs when eating
- ☐ My child had difficulty transitioning from the bottle/breast to table food
- ☐ My child refuses to eat, spits out or gags on food based on one or more of the following: temperature, food texture (crunchy or chewy foods), food color, smell,
- ☐ My child avoids touching certain foods/textures; if yes, please describe_____
- ☐ My child fidgets during mealtime
- ☐ My child frequently wipes his/her mouth
- ☐ My child is bothered by light touch to his/her face and or body
- ☐ My child exhibits sensitivities to one or more of the following (circle those that apply): itchy clothing, messy hands/face, excessive movement, loud noises
- ☐ My child exhibits one or more of the following oral motor sensitivities (circle those that apply): mouthing objects, gags or vomits frequently, bites/chews objects frequently, grinds teeth, difficulty tolerating brushing teeth
- ☐ Other (if other please describe)_____

Both the Feeding Questionnaire and 3-Day Food Diary will need to be returned for review. Our scheduling team will contact you to schedule your Feeding Evaluation after forms have been reviewed. You can return by Email, Fax, or Mail.

Email: Forms@Cheshirefitnesszone.com

Fax: 203-699-9611

Mail: 382 South Main St Cheshire, CT 06410

****Please return The Feeding Questionnaire & Food Diary to schedule a Feeding evaluation.**

3-Day Food Diary

Client Name: _____ D.O.B: _____

Please provide a detailed record of your child's food intake over a 3-day period. **Include all meals, snacks, and beverages.** Thank you!

	Day 1 **Date:_____**	**Day 2** **Date:_____**	**Day 3** **Date:_____**
Breakfast Time:			
Snacks Time:			
Lunch Time:			
Snacks Time:			
Dinner Time:			
Snacks Time:			

****Please return The Feeding Questionnaire & Food Diary to schedule a Feeding evaluation.**

SAMPLE 1-Day Food Diary

Client Name: _____Sammy Jones_____ **D.O.B:**____2/3_____

	Day 1 **Date: 1/12/2014**
Breakfast Time: 7:45AM	Ego waffle w/ syrup and butter Strawberries, grapes and 1/2 banana Glass of milk
Snacks Time: 10am	Mozzarella cheese stick Ritz crackers
Lunch Time: 12:30pm	Ham & cheese sandwich on white bread Goldfish crackers (cheddar) Carrot sticks dipped in ranch Fruit punch
Snacks Time: 3pm	Apple dipped in peanut butter
Dinner Time:5:30pm	Hamburger on wheat bun w/ lettuce, tomato and yellow mustard Sweet potato fries w/ ketchup Green beans w/ butter and salt Water
Snacks Time: 6:30pm	1 bowl of chocolate ice cream