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

Feeding Questionnaire (7yrs old and up)

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 or diet restrictions? If yes, please describe

_____

_____

3) Do you have concerns regarding your child's ability to swallow? Please describe results

_____

_____

4) Has your child had a Swallow Study completed? If yes, where was it completed?

_____

_____

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

_____

_____

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.

_____

_____

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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

7) 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 applies and please add any specific information that may be helpful.

- ☐ Change food texture (circle) 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?

_____

_____

_____

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For children 6 years and older

**** Please check off all that apply now or in the past. If in 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

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

Thank you.

The Feeding Team @ Cheshire Fitness Zone

****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