TherapyWorks L.L.C.

19 Halls Road, Suite 204
Old Lyme, CT 06371
Phone: (860) 434-5524

Nutrition and Feeding Questionnaire

Date: _____ Completed By:_____

General Information

Child's Name: _____ Birth date:_____

Height: _____ Weight: _____ Date of Measurements: _____

Address: _____

_____

Parent's Name: _____Phone :_____email: _____

Parent's Name: _____ Phone: _____email:_____

Prenatal and Birth History

Were there any of the following problems with the pregnancy, labor, or delivery?

___ gestational diabetes
___ abnormal ultrasound
___ trauma/injury/unusual stresses
___ preterm labor
___ infection
___ complications during delivery/labor
___ other

_____

_____

Was the child born: ___ Full term ___ Premature (_____weeks) Birth weight _____

Did your child have a NICU stay? (If so, for how long?) _____

Did your child have any of the following problems in the nursery?

___ gastroesophageal reflex (GER)
___ apnea
___ feeding/growth issues
___ tube feeding
___ difficulty latching on
___ bleeding in the brain
____required oxygen
___ was intubated

When did your child leave the hospital? (with mother, other time)

_____

How long was your child breast fed?

_____

If bottle fed, what type of formula was offered and for how long?_____

_____

Past Medical History

Has your child had any previous diagnosis/diagnoses that they do not currently have? (if so what was it/were they?) _____

_____

Medical History

Does your child currently have a diagnosis/diagnoses? (if so what is it/are they?)_____

_____

Does your child have any allergies? (if so, please list):_____

_____

Please list any medications your child takes:_____

_____

Please list any past medication your child has had:_____

Please list the vitamin, mineral, herb, and other nutritional supplements your child is currently taking:

Supplement	Product Name	Dosage	Comments

_____

PLEASE BRING SUPPLEMENTS TO FIRST VISIT. Thank you!

Please list any blood, urine, or stool laboratory test your child has completed within the past year (if available please attach a copy of the lab results) _____

_____

_____

_____

_____

Has your child had any surgeries? (If so, when did they occur and what were they for?) _____

_____

_____

Has your child had any procedures (i.e. pH probe, barium swallow)? (If so, when did they occur and what were they for?)_____

_____

_____

Has your child ever had a video fluoroscopic swallow study? _____ When?

_____

Results: _____

_____

Clinical

Does your child have more than 5 acute illnesses per year? _____

_____

Does your child have low muscle tone (i.e. appear "floppy") _____

_____

Does your child have high muscle tone (i.e. appear "stiff") _____

_____

Does your child have delayed expressive language skills? _____

Does your child have delayed receptive language skills? _____

Does your child have difficulty falling asleep? _____

_____

Does your child have difficulty staying asleep during the night? _____

_____

Do you have concerns about your child's behavior or symptoms you have noticed? _____

_____

_____

Has your child had a dental exam in the past year? (what was the date?) _____

Do you have any concerns with your child's dental health?_____

_____

Have there been concerns about weight gain or loss?_____

_____

Gastrointestinal

Has your child had any gastrointestinal diagnostic tests? (if yes, what were the results?) _____

_____

Does your child have any of the following gastrointestinal symptoms?

____undigested food in stool
___ bloated stomach
___ stomach pain
___ excess gas
___ constipation
___ diarrhea
___ loose stool
___ foul smelling stools
___ rarely or never has normal stools

What is the average number of bowel movements your child has per day? _____

What is the consistency of your child's stool on a typical day? _____

Allergies

Has your child been diagnosed with any food allergy/sensitivities or intolerances? (please list)

_____

Please list any allergy tests your child has had._____

_____

Do you suspect your child has a food allergy? (please list)_____

_____

Do the child's parents or siblings have any food allergies? (please list) _____

_____

Does your child have any of the following food allergy symptoms?

___ reflux as an infant
___colic as an infant
___reflux
___vomiting
____ear infections
____runny nose
___sneezing
___wheezing
___ asthma
___ eczema
___ hives
___ skin rash
___ dark circles under eyes
___ headaches
___ gastrointestinal (i.e. diarrhea, constipation)

_____

_____

Has your child been diagnosed with airborne allergies? _____

Dietary

Are you concerned about your child's diet? _____

_____

_____

Do you feel like your child eats ___ too much, ___ enough, or ___ too little food?

Does your child eat breakfast? _____

Does your child wake up hungry?_____

Do you have any concerns about your child's weight, fitness, or muscle strength? _____

_____

Have you tried any of the following diets with your child?

Diet	No (did not try)	Yes (helped)	Yes (made worse)	Yes (not sure)
Gluten Free				
Specific Carbohydrate Diet™				
Antifungal (yeast-free)				
Feingold				
Low Oxalate				
No Phenol				
Food Elimination/Challenge				
Gluten/Casein Free				
Other:				
Other:				

_____

Grains

Is your child on a Gluten Free Diet? _____

What type(s) of bread does your child eat? ___ white ___wheat ___ Gluten Free

_____

What type(s) of flour do you cook with? _____

How often does your child eat:

	Daily	Weekly	Seldom	Never
Breads				
Hot Cereal				
Cold, dry cereal				
Brown Rice				
Pasta				

Dairy

Is your child on a Casein Free Diet? _____

What type of milk does your child drink? ___ whole ___ low fat ___ skim ___ soy
___ almond ___ coconut ___ goat ___rice
___ other

_____

How often does your child eat:

	Daily	Weekly	Seldom	Never
Milk				
Yogurt				
Cheese				
Juice (fortified with calcium)				

Fruits and Vegetables

Does your child eat at least 5 servings of fruits and vegetables daily? _____

Does your child eat a citrus fruit or dark leafy vegetable daily? _____

Do you wash your fresh produce with "veggie wash"? _____

Do you purchase organic grown produce? _____

Fiber

How often does your child eat:

	Daily	Weekly	Seldom	Never
Fresh fruits and vegetables				
Whole Grains				
Dried beans and peas				

Meat, Poultry, Fish, Dry Beans, Eggs, Nuts, and/or Alternatives

How often does your child eat:

	Daily	Weekly	Seldom	Never
Red Meats				
Pork				
Veal or Lamb				
Poultry				
Fish				
Dry Beans and Peas				
Eggs				
Nuts and/or Seeds				
Tofu, Soy, and/or Soybeans				
Peanut Butter				

Fats and Oils

What types of oils do you use? ___ canola ___ olive ___ soybean ___ corn ___ other

Does your child eat: ___ butter ___ margarine ___ nut butters

Do you cook with solid fats such as Crisco or Lard? _____

Do you use flaxseed for cooking or in food preparation? _____

Water

How many cups of water does your child drink daily? _____

What type of water does your child drink? ___ tap
___ bottled (Brand_____)
___ filtered (Type _____)

Sugar

Does your child eat: ___ table sugar ___ brown sugar ___ honey
____artificial sweeteners ___ fructose ___ Stevia
____agave ___ maple sugar

How often does your child eat:

	Daily	Weekly	Seldom	Never
Candy				
Sweets (i.e. cookies, cake, pie)				
Cola/soft drinks				
Kool-aid				
Fruit Punch				
Gatorade or sports drinks				
Packaged/prepared foods				
At fast food restaurants				

Likes/Dislikes

Please list your child's favorite foods: _____

_____

_____

Please list your child's favorite snacks: _____

_____

_____

Please list foods your child dislikes: _____

_____

_____

Please indicate which foods (if any) your child currently avoids/refuses to eat.

___ fruits
___ vegetables
___ meats
___ starches
___ purees
___ lumpy
___ crunchy
___ chewy
___ smooth
___ soft
___ hard
___ fluids
___ mixed textures
___ salty
___ sweet
___ spicy
___ tart
___ bland

_____

_____

Please indicate which foods (if any) your child currently craves/seeks out.

___ fruits
___ vegetables
___ meats
___ starches
___ purees
___ lumpy
___ crunchy
___ chewy
___ smooth
___ soft
___ hard
___ fluids
___ mixed textures
___ salty
___ sweet
___ spicy
___ tart
___ bland

_____

_____

Does your child refuse foods of a certain flavor, smell, or temperature? _____

_____

Can your child "make do" with less favored foods, or refused foods without becoming upset? _____

_____

Environment

Who does your child eat with at:

Breakfast _____ Snacks: AM, PM, Evening

Lunch _____ _____

Dinner _____ _____

_____

_____

Who feeds your child?

___ him/herself
___ mother
___ father
___ siblings
___ grandparent
___ teacher
___ daycare provider
___ other

_____

Are there family rules around trying new foods or finishing foods?

_____

_____

What is the general feeling at your mealtimes? (pleasant, stressful, power struggle)

_____

_____

_____

_____

What room does your child eat in?

___ kitchen
___ dining room
___ living room
___ walking around
___ other

_____

Where does your child sit during meal times?

___ infant seat
___ highchair
___ booster seat
___ chair at table
___ child stands
___ child wanders around
___ in front of TV
___ held in caregiver's arms
___ on caregiver's lap
___ other

_____

_____

What position is your child in for meals?

___ seated with feet supported
___ seated with feet hanging
___ reclined in high chair
___ supported on caregivers lap
___ laying on caregiver's lap

Are there distractions such as the television, toys, radio, etc. during meals? _____

_____

Feeding

How does your child currently receive liquids? ____ bottle ____ sippy cup ____ cup ____ straw

If tube fed, what type of tube does your child currently use? ___ ng-tube ___ g-tube
___ g-j-tube ___ j-tube

Does your child appear interested in eating or find eating pleasurable? _____

_____

Does your child use any special equipment or utensils? (i.e. coated spoon, training cup, special spoon)? _____

Does your child feed him/herself? _____

Finger feeding - ___ beginning, ___ partially successful, or ___ completely successful
Feeds self with food - ___ beginning, ___ partially successful, or ___ completely successful
Bring drink to mouth - ___ beginning, ___ partially successful, or ___ completely successful

Does your child display any of the following during meals? (check all that apply)

___ gagging/coughing on textures
___ vomiting
___ spitting food out
___ clears throat
___ overfill mouth
___ refuses to eat
___ drool heavily
___ panting/difficulty breathing
___ have trouble keeping food in mouth
___ choking
___ limited volume/not eating enough
___ difficulty swallowing
___ difficulty chewing
___ refuses to swallow/holds food in mouth
___ difficulty progressing to table food
___ crying
___ screaming
___ throws food/utensils
___ tries to get out of seat
___ falls asleep
___dislikes utensils on lips
___ other (specify)

_____

_____

Please check your child's current ability to eat the following food textures.

Texture	Eats Easily	Eats with difficulty	Refuses	Cannot Eat	Never tried
Baby food					
Puree table food (i.e. mashed potatoes, applesauce)					
Mashed table food					
Soft finger solids					
Chopped table food					
Soft table food (i.e. pancakes)					
Crunchy table food (i.e. apple, crackers)					
Difficult to chew table food (i.e. meat)					

_____

_____

Does your child have any physical pain while eating/drinking?

None Mild Moderate Severe

0 1 2 3 4 5 6 7 8 9 10

Approximately when did your child began eating:

Pureed food _____

Soft foods, mashed table food _____

Coarsely chopped/easily chewed foods _____

Coarsely chopped foods (including most meats and vegetables) _____

Standard table foods _____

Drinking from a cup _____

Does your child have a history of: ___ Reflux ___ problems with breast-feeding
___ problems with bottle feedings ___ fed a special formula as an infant
___ difficulty transitioning from baby food to table foods

Has there been an abrupt change in eating habits lasting longer than 30 days?_____

Does your child eat a limited variety of foods? (less than 20 foods) _____

How does your child react when presented with new foods? _____

_____

Has your child discontinued eating foods he/she used to eat? _____

Does your child have any routines before, during or after meal time?

_____

_____

Does your child come to the table at family meals, even if not eating by mouth?

_____

Does your child take an extended period of time (longer than 30 minutes) to eat a meal?_____

_____

Does your child have a good appetite? _____

_____

Have you needed to utilize any of the following strategies?

___ distraction during meals (i.e. games, TV)
___ skipping meals
___ rewards
___ feeding child when he/she requests food
___ coaxing
___ forcing
___ allowing child to drink more fluids
___ giving preferred foods
___ punishment
___ high calorie supplements/formula
___ use candy as an reward
___ other _____

Are you concerned that your child has a feeding problem? If so, what is your primary concern?

___ Not eating enough variety
___ Not eating enough volume
___ Eating too much
___Food refusal
___ Poor growth
___Transitioning from tube to oral feeding
___ Gagging
___ Vomiting
___ Avoiding whole food groups
___Only eats purees (i.e. applesauce)
___ Only eats crunchy solids
___Only drinks fluids
___ Aspiration
___ Constipation
___ Diarrhea
___ Tooth brushing intoleranc

Does your child assist with food preparation and shopping?

_____

Are there any further comments about eating together, holidays, traditional foods, dietary preferences, expectations about feeding, mealtimes, or family rules not previously mentioned?

_____

_____

Movement

Activity Level:

_____ *Sedentary* – Light activities, no exercise; sitting quietly, riding in car
_____ Light – *Sedentary* plus 1-1.5 hrs of *leisure*: playing in pool, walking, biking
_____ Moderate- *Sedentary* plus 1-2 hours of daily: *slow* swimming, cycling, walking Etc
_____ Very Active – *Sedentary* plus 1-2 of daily "heart active" activities: climbing hills, cycling, rope skipping, skating skiing, swimming, running

_____
_____
_____

Other Information

Has your child seen a Registered Dietitian in the past? _____

Does your child currently receive any therapy services?

___ Speech/Language ___ school-based ___ out-patient
___ OT ___school-based ___ out-patient
___ PT ___ school-based ___ out-patient
___ Feeding therapy ___ school-based ___ out-patient
___ Other

Does your child have a therapy plan? ____ IFSP ____ IEP ____ Other

Please provide any other information you would like me to know about your child:

_____

_____

_____

_____

_____

_____

****If possible, please bring a video of a meal time with you so the therapist(s) can see what a typical meal is like for your child. Thank you! ****