Pediatric Feeding and Swallowing Questionnaire

Please complete the following form and mail or email to ReImagine Speech Therapy prior to your child's Speech Therapy Evaluation.

Demographics

Name of Child _____
Date of Birth _____
Chronological age _____
Gestational age _____
Current weight _____
Mother's name _____
Father's name _____

Child's Current Status

What is the child's medical diagnosis? _____
What are the present concerns? _____
Has the problem worsened or improved? _____
Are there times when the problem is better or worse? _____

Social History

With whom is the child living? _____
Names and ages of siblings _____
Who are the primary caregivers? _____
Who usually feeds the child? _____

Medical History

List maternal illnesses or infections during pregnancy _____
List any problems during pregnancy _____
List all medications taken during pregnancy _____
Tests/xrays during pregnancy _____
Alcohol/drug use prior to pregnancy _____
Length of pregnancy _____
Duration of active labor _____
Type of delivery _____
___ Head first ___ Feet first ___ Breech
Complications during labor and delivery _____
Type of anesthesia used during birth? _____

info@reimaginespeech.com
PO Box 1743 McKinney TX, 75070

Apgar scores: 1 minute _____ 5 minutes _____
Did your child need ventilator support at birth? _____
Did your child spend time in the NICU? _____
If yes, for what reason? _____
List any medications your child is taking _____
List and describe any surgeries _____

Has your child experienced any of the following?
_____ Ear infections _____ Allergies
_____ Asthma _____ High fevers
_____ Upper respiratory infections _____ Pneumonia
Other illnesses _____

Any genetic or neurological testing been conducted? _____
If yes, explain _____
Is your child irritable at times? _____
Does your child experience constipation? _____
Is your child toilet trained? Bladder _____ Bowel _____

Motor Development
Age of milestones:
Sat alone _____ Crawled _____ Walked _____
Hand preference _____
Activities your child can do independently:
Dressing _____ Bathing _____ Toileting _____ Eating _____
Other? _____
Describe gross or fine motor problems _____

Speech and Language Development
Age of milestones:
Babbling _____ First word _____ Two-word combinations _____
What were the first 3-4 words? _____
Estimated number of words in your child's expressive vocabulary? _____
Is your child quiet, noisy or average? _____
Is your child easy to understand? _____
How does your child communicate? _____
Does your child understand questions and directions? _____
Describe his/her vocal quality:
_____ Breathy _____ Shrill _____ Hypernasal _____ Gurgly
_____ Weak _____ Hyponasal _____ Wet

Personality
Your child's likes and dislikes _____

Favorite toys and activities _____
Any fears? _____
What kinds of situations frustrate your child? _____
Types of discipline used? _____
When is your child's bedtime and rising time? _____
Does your child take naps? _____ How long? _____
Describe your child's sleep patterns _____
Any sleep problems? _____

Feeding and Swallowing History

Was the child breast fed? _____
If so, for how long? _____
Any problems? _____
Has a feeding tube ever been used and how long? _____
What does your child eat in a typical day? List foods and amount:
Morning _____
Afternoon _____
Evening _____
Duration of average feeding/meal _____
How many times a day does your child eat? _____
Amount of liquid consumption in one day _____
Amount of food consumption in one day _____
Favorite foods _____
What foods/liquids appear to be difficult for your child to eat? _____
_____

How is your child positioned during feedings?

_____ Held in your lap
_____ Infant seat
_____ High chair
_____ Sitting in wheelchair
_____ Booster seat
_____ Sitting in a chair at a table
_____ Lying down
_____ Other _____

What utensils are used and at what age were they introduced?

Bottle _____ Spoon or fork _____
Fingers _____ Sippy cup _____
Straw _____ Cup (no lid) _____
Other _____
Is adaptive equipment used during feedings? _____
When did your child stop using a bottle? _____
Does your child feed himself/herself? _____
If yes, with what? _____

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What kinds of food does your child eat most of the time? _____
_____
What age were solids introduced? _____
What food does your child NOT like? _____
_____
Are there textures your child will NOT eat? _____
_____
Are there colors your child will NOT eat? _____
_____

Does your child consume any nutritional supplements? _____
How do you know your child is hungry? _____
How do you know when your child is full? _____

Please check those that apply:

_____ Choking during a meal
_____ Food or liquid coming out of nose
_____ Eats too much
_____ Difficulty swallowing
_____ Trouble breathing during feeding
_____ Fussing during feeding
_____ Spitting food out
_____ Postural changes during feeding
  _____ Stiffening _____ Hyperextending
_____ Noisy breathing
  _____ Before _____ During _____ After
_____ Gurgly voice quality
  _____ Before _____ During _____ After
_____ Gagging during a meal
_____ Cries during meal
_____ Eats too little
_____ Reflux during/after meals
_____ Emesis during/after meals
_____ Falling asleep during feeding
_____ Refuses oral feeding

Has your child ever turned blue during or after a feeding? _____
Is your child having trouble gaining weight? _____

Are meal times pleasant? _____
Does your child have behavior problems during mealtime? _____

_____ Throws food
_____ Spits food
_____ Cries, screams
_____ Leaves table before finished
_____ Other? _____
_____ Messy eater
_____ Refuses to eat
_____ Takes food from other's plate

Does your child use a pacifier? _____
Does your child have difficulty with movements of his/her mouth? _____
Is your child aversive to touch on his/her face? _____
Does your child drool?

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_____ Never _____ Occasionally _____ Constantly
_____ Rarely _____ Frequently

What seem to help (or not help) your child during mealtimes? _____
_____

Any other information you would like to add? _____
_____
_____
_____

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