



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

Patient name: _____

Date of Birth: _____

Today's Date _____

Insurance Provider:	
ID #:	

Fill out this Feeding Questionnaire and 3-Day Food Diary to start the process for a Feeding Evaluation. Please complete this survey by providing as detailed information as possible. 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

Feeding Questionnaire

(For Children 7 years old and older)

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 provide details.



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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 use more details 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 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



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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?

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

- | | |
|--|---|
| <input type="checkbox"/> constantly wiping face at meal time | <input type="checkbox"/> Intolerant of food on hands |
| <input type="checkbox"/> food all over face | <input type="checkbox"/> improvements in eating with background noise |
| <input type="checkbox"/> only closes lips when cued | <input type="checkbox"/> mouths objects |
| <input type="checkbox"/> only chews on one side | <input type="checkbox"/> bites or chews objects or clothing frequently |
| <input type="checkbox"/> loses control of liquid | <input type="checkbox"/> sensitive to itchy clothing |
| <input type="checkbox"/> coughing during or shortly after eating | <input type="checkbox"/> sensitive to excessive movement |
| <input type="checkbox"/> sounds congested after eating | <input type="checkbox"/> sensitive to loud noises |
| <input type="checkbox"/> grinding of teeth | <input type="checkbox"/> shows strong preferences for soft food |
| <input type="checkbox"/> avoids touching different foods or textures | <input type="checkbox"/> shows strong preference for crunchy food |
| <input type="checkbox"/> avoids certain flavors or spices | <input type="checkbox"/> shows strong preference for chewy food |
| <input type="checkbox"/> easily distracted when eating | <input type="checkbox"/> shows strong preference for a certain colored food |
| <input type="checkbox"/> stuffs food in mouth | <input type="checkbox"/> avoids mixed textured food |
| <input type="checkbox"/> puffs cheeks when drinking liquids | |
| <input type="checkbox"/> bothered by light touch to face or body | |



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3-Day Food Diary

Client Name: _____

D.O.B.: _____

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

	Date:	Date:	Date:
Breakfast Time:			
Snacks Time:			
Lunch Time:			
Snacks Time:			
Dinner Time:			
Snacks Time:			



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SAMPLE 1-Day Food Diary

Client Name: ___Sammy Jones_____ **D.O.B:** ___2/3/2015_____

	Day 1 Date: 1/12/2019
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