****Please return The Feeding Questionnaire & Feeding Routine 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 Coordinator 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: 203-699-9641** **Mail: 382 South Main St Cheshire, CT 06410**

Feeding Questionnaire

(For Children Birth to 12 months old)

Primary method of feeding within the past week (circle one): BOTTLE -- BREASTFEEDING

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.

____

____

For children eating any solid food:

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) ____________________

7) Additional information
**Please check all that apply now or in the past. If in the past, how old was your child?
- ☐ 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: itchy clothing, messy hands/face, excessive movement, loud noises
- ☐ My child exhibits one or more of the following oral motor sensitivities: mouthing objects, gags or vomits frequently, bites/chews objects frequently, grinds teeth, difficulty tolerating brushing teeth
- ☐ Other (if other please describe)____________________

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Feeding Routine

Client Name: ______________________ **D.O.B:** ______________________
Date:______________________

Please provide detailed bottle/breastfeeding routine for a typical 24 hour period

Bottle brand and nipple flow rate used:______________________

Start Time – End Time	Quantity	Comments (awake/asleep, spitting up etc)