Rehabilitation Associates, Inc.

Feeding Intake Questionnaire

Child's Name: _____ **Date of Birth**: _____

Parent/Caregiver Names:_____

Medical and Developmental Diagnoses:_____

Food Allergies:_____

Dietary Requirements or Restrictions:_____

Family goals for child's feeding/eating:_____

MEDICAL HISTORY

☐Reflux/ Eosinophilic / Esophagitis ☐Delayed Emptying/ Slow Motility

☐Feeding Tube Dependence (see below) ☐ Ear Infections

☐Upper Respiratory Infection ☐Pneumonia

☐Aspiration ☐Bowel Movements (Diarrhea or Constipation)

☐ Swallow study or an endoscopy?_____

ORAL MOTOR AND SELF FEEDING SKILLS

1. Problems during meals:

☐Gagging ☐Coughing ☐Poor suck ☐Trouble chewing ☐Tongue thrust

☐Moving tongue side to side ☐Difficulty biting off food ☐Difficulty drinking

☐Loses food/liquid from mouth ☐Poor lip closure ☐Difficulty swallowing

☐Drooling ☐Other: _____

2. Food Textures tolerated:

☐Stage 1 or 2 baby food ☐Stage 3 baby food

☐Pureed table foods - smooth ☐Pureed table food - with lumps

☐Wet ground (like meat sauce) ☐Mashed table foods

☐Meltable solids (cheese puffs) ☐Soft solids (bananas, mac and cheese)

☐Crunchy foods (hard cookie, raw vegetables)

☐Chewy foods (meat, gummy candy, granola bar

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3. Can your child use the following utensils?

- ☐ Spoon
- ☐ Fork
- ☐ Baby Bottle
- ☐ Sippy Cup
- ☐ Straw
- ☐ Open cup
- ☐ Water Bottle
- ☐ Was your child ever Breast Fed? ***Yes or No***

CURRENT FEEDING PRACTICES

Where does your child eat?

☐High Chair ☐Booster Seat ☐Lap ☐Lying down

☐Table/Chair ☐Walking around ☐Other: _____

Mealtime Behaviors: (Please circle all behaviors that your child exhibits during mealtimes)

☐Spits out food ☐Pushes food away ☐Turns head ☐Keeps mouth shut

☐Screams/cries ☐Overstuffs ☐Leaves the table ☐Holds food in mouth

☐Eats too fast ☐Eats too slow ☐Throws food ☐Tantrums

FOOD PREFERENCES AND MEALTIME BEHAVIORS

1. At what point does your child start to refuse foods? (Visual/sight, smell, touch, taste)

   _____

2. Can your child tolerate nonpreferred foods on his/her plate? *Y or N* On the table? *Y or N*
3. Does your child show interest in other people's food? *Y or N*
4. Does your child eat the same or differently across settings? Restaurant, school, friends' or family's house? _____

5. What have you tried to do in order to get your child to eat?

   ☐Toy ☐TV ☐Talking/Singing ☐Offer preferred foods, toys, activities

   ☐Time out ☐Remove privileges ☐Mix/sneak non-preferred foods into favorites

   ☐Cook only preferred foods ☐Allow child to eat whenever hungry (graze)

   ☐Other: _____

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Were the following tube feedings used? ☐G-Tube ☐ J-Tube ☐NG-Tube ☐NJ-tube

Tube feeding information (If applicable) and please indicate times & amount:

Current Tube Type:	
% of daily calories via tube:	
Type of formula:	
	☐Bolus ☐Continuous
Vomiting or other problems with tube feedings:	

Times	Amount

Food Preference Checklist

Please circle all foods your child eats.

Starches:

Bread	Baked Potato	Macaroni & Cheese	Waffles
Oatmeal	Spaghetti	Corn	Pancakes
French Fries	Rice	Cereal (please list):	French toast
Mashed Potatoes	Noodles		Muffins

Other: _____

Fruits:

Orange Juice	Cantaloupe	Pineapple	Strawberries
Apple Juice	Fruit Cocktail	Applesauce	Apple
Grape Juice	Peach	Orange	Dried Fruit
Watermelon	Pear	Banana	

Other: _____

Vegetables:

Green beans	Lettuce/salad	Spinach	Sweet Potato	Peas
Carrots	Broccoli	Tomatoes	Peppers	

Other: _____

Milk/Dairy:

Milk- Type:	Ice Cream	Yogurt- Type:	
Chocolate/ Flavored Milk	Soy/Almond Milk	Pudding	Cheese- Type:

Other: _____

Meat/Protein:

Chicken	Ham	Fish	Pork	Eggs
Chicken nuggets	Roast Beef	Fish Sticks	Hot Dogs	Grilled Cheese
Hamburger	Turkey	Sausage	Steak	Nut Butter - Type:

Nuts Other: _____

Mixed Textures:

Pasta with sauce	Pizza	Sandwiches	Casseroles	Tacos/Burritos

Other:

_____

Extras:

Margarine	Jelly	Ketchup	Mayonnaise	Salad Dressing	Syrup
Mustard	Cream Cheese				

Other: _____

Snacks:

Cookies	Chips	Poptarts	Pretzels	Crackers	Goldfish
Soda	Kool-aid				

Other: _____

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Please provide a diary of what your child eats 3 days of the week before your initial evaluation.

Day 1

Meal	Time of Day	Foods Eaten	Amount of Food (Ex: 2 bites of toast, 1 bowl of soup, ½ of a granola bar)
Breakfast			
Lunch			
Dinner			
Snacks			

Day 2

Meal	Time of Day	Foods Eaten	Amount of Food (Ex: 2 bites of toast, 1 bowl of soup, ½ of a granola bar)
Breakfast			
Lunch			
Dinner			

Snacks			

Day 3

Meal	Time of Day	Foods Eaten	Amount of Food (Ex: 2 bites of toast, 1 bowl of soup, ½ of a granola bar)
Breakfast			
Lunch			
Dinner			
Snacks			