Occupational Therapy Feeding Evaluation Questionnaire

Date: ________________

Has your child ever seen another **specialist** (such as a gastroenterologist, nutritionist or feeding therapist) for feeding difficulties?  
Yes  No

If yes, specify: ____________________________________________________________

Does the child have any **food allergies** or **intolerances**?  
Yes  No

If yes, describe: __________________________________________________________

Has your child ever had a **dysphagia or upper gastrointestinal tract study**?  
Yes  No

If yes, where? ___________________________  When? ___________________________

Results: _________________________________________________________________

Has a professional ever given your child a specific **diagnosis**? (circle all that apply)

- Bronchopulmonary dysplasia  
- Cerebral palsy  
- Chronic lung disease  
- Cleft lip/palate  
- Congenital heart disease  
- Developmental delay  
- Down Syndrome  
- Failure To Thrive/poor weight gain  
- Other: ________________________________________________________________

Has your child ever been **hospitalized** or had any **surgical procedures**? (circle all that apply)

- Allergies  
- Asthma  
- Bronchitis  
- Dehydration  
- Failure to thrive  
- Gastroesophageal reflux  
- Other: ________________________________________________________________

Has your child ever been **hospitalized** or had any **surgical procedures**? (circle all that apply)

- Gastrostomy  
- Nissen fundoplication  
- Pneumonia  
- PE tubes  
- RSV  
- Tonsillectomy/adenectomy  
- Other: ________________________________________________________________

Does your child exhibit any of the following? (circle all that apply)

- Difficulty with sucking  
- Gagging  
- Vomiting with meals  
- Teeth Grinding  
- Drooling  
- Other: ________________________________________________________________

Does your child exhibit any of the following behaviors during mealtimes? (circle all that apply)

- Crying  
- Spitting  
- Throwing food  
- Vomiting  
- Other: ________________________________________________________________

- Holding food in mouth  
- Turning away  
- Pushing food/utensils away  
- Focusing on toys/television during mealtimes  
- Other: ________________________________________________________________
What food does your child currently take? What is his/her *response to these foods*?

<table>
<thead>
<tr>
<th>Food</th>
<th>No Difficulty</th>
<th>Gagging</th>
<th>Choking</th>
<th>Coughing</th>
<th>Vomiting</th>
<th>Congestion</th>
<th>Wet Voice</th>
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</thead>
<tbody>
<tr>
<td>Formula / Breastmilk</td>
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<tr>
<td>Baby Food (Stage 1 or 2)</td>
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<td>Lumpy Baby Food (Stage 3)</td>
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<td>Soft Chewable Solids (pasta, canned fruit, cooked vegetables)</td>
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<td>Hard Chewable Solids (cookies, crackers)</td>
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<td>Chewy Foods (meats)</td>
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</tbody>
</table>

What are some of your child’s **preferred foods**? ______________________________________________________

What are some of your child’s **non-preferred foods**? ____________________________________________________

Describe a **typical mealtime** (Where seated, typical routine, duration of meal) ____________________________

Please provide any other **concerns** you may have about feeding: __________________________________________

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**For tube-fed children only**

Which type of tube does your child have: gastrostomy tube  nasogastric tube  nasojejunal tube

How does your child receive his/her feedings:

**Continuous feed:** ______ ml / oz in ______ hours
  
  Beginning time: ______ Ending time: ______
  
  Beginning time: ______ Ending time: ______

**Bolus feed:** ______ ml / oz per feeding
  
  Given at _______, _______, _______, _______, _______, _______, _______