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Supplemental Feeding Evaluation / Modified Barium Swallow Study Intake Questionnaire

PLEASE BRING THIS WITH YOU FOR YOUR CHILD'S EVALUATION

Labor: (check all that apply)

☐ Vaginal ☐ Forceps/Vacuum
☐ C-section ☐ Breech
☐ Nuchal Cord ☐ Other:_____

Sleeping Position:

Amount of Time Spent Prone (on the tummy) Per Day:

Spends Most of the Day (position):

Describe your child's sleep patterns:

☐ Lengthy/multiple night wakings ☐ Snoring ☐ Mouth breathing
☐ Normal (sleeps through night) ☐ Other: _____

Describe your child's voice quality:

☐ Breathy ☐ Shrill ☐ Hypernasal ☐ Gurgly ☐ Weak ☐ Hyponasal ☐ Normal

Pitch of Voice: ☐ Normal ☐ Too High ☐ Too Low

Volume: ☐ Normal ☐ Weak ☐ Loud

Is/Was your child breastfed?
For how long/how often: _____
Were there any problems: (please describe) _____

Is/Was your child fed through a feeding tube?
What type: _____
For how long: _____ weeks _____ months _____ years
How often: _____

What does your child eat in a typical day? (List main foods and approximate amounts)

Morning _____

Afternoon _____

Evening _____

Duration of average feeding: How long does it take the child to complete a meal?

☐ Less than 10 minutes ☐ 10-20 minutes ☐ 20-30 minutes ☐ Over 30 minutes

How many times a day does your child eat? _____

Estimated amount of liquid consumed per day? _____

Estimated amount of food consumed per day? _____

What are your child's favorite foods?

What foods/liquids appear to be more difficult for your child to eat?

How is your child usually positioned during a feeding?

☐ Held on lap ☐ Cradle held ☐ Side lying position ☐ Infant seat

☐ High chair ☐ Booster seat ☐ Sitting in chair at table ☐ Sitting in wheelchair

☐ Lying down ☐ Other _____

What utensils are usually used and at what age were they introduced:

Bottle _____ Nipple Type: _____ Bottle Type: _____
Fingers _____ Spoon or Fork _____
Sippy Cup _____ What kind: (ex. First years) _____
Straw _____ Cup (no lid) _____
Other _____

At what age did your child stop using a bottle? _____

What kinds of food does your child eat most of the time?

☐ Breast milk ☐ Formula ☐ Baby foods (what stage?) _____

☐ Mashed table food ☐ Chopped table food ☐ Regular table food ☐ Other:_____

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At what age was solid food introduced? _____

Did your child easily transition to solid foods? ☐ Yes ☐ No

What foods does your child NOT like to eat? _____

How do you know when your child is hungry? _____

How do you know when your child is full? _____

Please check those that apply to your child:

- ☐ Coughing during /after feeds
- ☐ Choking during meal
- ☐ Food/liquid coming out of nose
- ☐ Difficulty swallowing
- ☐ Trouble breathing during feeding
- ☐ Spitting food out
- ☐ Fussing during feeding
- ☐ Head turning to avoid feeding
- ☐ Postural changes during feeding:
  - ☐ stiffening ☐ hyperextending (arching)
- ☐ Gagging during meal; after feeding (at least 30 min)
- ☐ Cries during meals
- ☐ Eats too little ☐ Eats too much
- ☐ Reflux during / after meals
- ☐ Falling asleep during feeding
- ☐ Vomiting during / after meals
- ☐ Refuses oral feeding
- ☐ Difficulty with weight gain
- ☐ Noisy breathing:(during, before or after)
- ☐ Gurgly voice quality:(during, before or after)

Has your child ever turned blue during or after a feeding? _____

Appetite: ☐ Good ☐ Inconsistent ☐ Poor

Does your child exhibit: (please describe)
Food Allergies or Intolerance: _____

Preferred food temperatures ☐ Warm ☐ Cold
Preferred liquid temperatures ☐ Warm ☐ Cold
Location for feeding ☐ One place (Where?) _____ ☐ Several places

Does your child have behavior difficulties during mealtimes? (check all that apply):

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

Does your child use a pacifier? ☐ Yes ☐ No

How much does your child drool?
☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Constantly

What seems to help (or not help) your child during mealtime?

Sensory: (please check yes or no for each statement)		
My child dislikes being messy.	☐Yes	☐No
My child is a "picky eater".	☐Yes	☐No
My child seems to constantly be "on the go", having difficulty sitting still.	☐Yes	☐No
My child becomes upset with brushing teeth/hair, bathing, dressing/undressing.	☐Yes	☐No
My child "melts-down" when there is a change in routine, or something unplanned comes up.	☐Yes	☐No
My child becomes easily frustrated and frequently has tantrums.	☐Yes	☐No
My child appears not to "tune-in" to what I say, even though his/her hearing is fine.	☐Yes	☐No

Self-Care Skills: (please check yes or no for each statement)		
My child is able to feed him/herself independently using a spoon.	☐Yes	☐No
My child is able to feed him/herself independently using a fork.	☐Yes	☐No
My child is able to drink from an open-cup or from a straw.	☐Yes	☐No
My child is able to bathe him/herself independently with only verbal reminders.	☐Yes	☐No
My child is toilet trained. Age potty trained_____	☐Yes	☐No

Please bring foods that your child likes to eat and this questionnaire to your appointment. As age appropriate, bring liquid, soft/puree food, something that must be chewed (ex: fruit cup) and regular table food item (cracker, cookie, sandwich). If possible, please bring bottles/cups and utensils your child typically uses, to make your child more comfortable during the evaluation.

I acknowledge that I have received a copy of the *Welcome to Pediatric Therapy Services* orientation packet.

Caregiver Signature:_____ Date:_____