The Boston Ability Center

Feeding Questionnaire

Child's Name:_____ Date:_____

Name of person filling out and relationship to Child:_____

If choice given, please circle answer

CURRENT FEEDING PROBLEMS

What problems is your child now having?

☐ Will not eat enough food by mouth

☐ Refuses to eat certain kinds of food (smooth, lumpy, crunchy, spicy) Describe: _____

_____

☐ Seems to have problems taking liquids. Describe: _____

_____

☐ Seems to have difficulty with solid foods. Describe:_____

_____

☐ Seems to have difficulty with temperature of food or liquids (too hot or too cold)

☐ Other:_____

When did you first notice feeding problems?_____

_____

_____

_____

FEEDING HISTORY

Was your child:

Breastfed Yes No When stopped_____

Bottle-fed Yes No When stopped_____ Type of Bottle_____ Nipple_____

Were there any problems with breastfeeding?_____

_____

Were there any problems with bottle feeding?_____

_____

When did you first introduce solid foods?_____

_____

Has your child ever needed:

Type of feed	When started	When stopped
NG (nasogastric tube feeds)	_____	_____
OG (oral gavage feeds)	_____	_____
NJ (nasojejunaal feeds)	_____	_____
GT (gastrostomy tube feeds)	_____	_____
TPN (total parental nutrition)	_____	_____
JT (jujunal feeds)	_____	_____

CURRENT FEEDING SKILLS

On average, how many ounces does your child drink a day? _____ounces

How many bottles a day does your child drink? _____

How many cups a day does your child drink? _____

What liquids does your child now take?

Milk: _____ounces

Formula: _____ounces Which Formula?

Juice: _____ounces

Water: _____ounces

Non-Oral Feeds: _____ounces How often?_____

Food my child likes	Food my child dislikes
_____	_____
_____	_____
_____	_____

How long does it usually take for your child to eat a meal?

30 minutes or less 30 -60 minutes

FEEDING BEHAVIORS

Behavior noted during feeding (circle all that apply)

Gets tired easily	Poor appetite	Refuses bites offered
Vomits during feeding	Vomits after feeding	Chews but does not swallow
Cries during feeding	Leaves the table	Loses lots of food out of front of mouth
Tantrums	Purposeful spit	Eating time is stressful for child/parent

Other _____

Please describe other concerns about your child's behavior or emotional condition: _____

_____

ORAL-MOTOR, RESPIRATORY AND GI ISSUES

Does your child allow you to brush his or her teeth? Yes No

Does he or she tolerate this well? _____

Does your child have a history of: (circle all that apply)

Gagging	Drooling	Long-term NPO
Choking	Gurgly vocal quality	Colds that last too long
Wheezing	Aspiration	Pneumonia
Hoarse Voice	Crying after feedings	Constipation
Inability to gain weight	Nausea	Chronic diarrhea

FEEDING ENVIRONMENT

Who usually feeds your child? _____

What works best when trying to feed your child?_____

_____

Where do you feed your child most often? _____

_____

Which meal does your child do best with? Breakfast Lunch Dinner

Is there a difference in your child's feeding when eating with family or peers versus alone? _____

_____