"Creating the best life for all children"

Beavercreek ○ Miamisburg ○ Middletown ○ Red Bank Road ○ West Chester ○ Western Hills
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Parent Questionnaire for OT Feeding Evaluations
(please return to the evaluating therapist at the end of the evaluation)

Child's Name: ___________________________
Date of Birth: ___________________________
Respondent and relationship to child: ____
Child's weight: ___________________________
Percentile rank for weight: __________________
Who does the child reside with? ______________

Background History:
Vision:
Have they been screened in the last year? Yes No
Date of last screening: ___________
Wears glasses: Yes No
Vision concerns: far sighted near sighted
Name of vision clinic or doctor: _____________________________

Hearing:
Have they been screened in the last year? Yes No
Date of last screening: _________
Do they have PE (Eustachian) tubes? Yes No
Were there deficits with their hearing test? Yes No
If they do have deficits please describe them: _________________________________

Please list any diagnosis your child may have: ____

Hospitalizations/Surgeries: Yes No
Describe or list the hospitalizations/surgeries:
____
____

Medications: Yes No
List medications: ____

Preferred food list: ____

List foods they avoid: ____

Fluids they drink: water juice formula supplemental drinks

Self-care skills:

Feeding:

- How do they get their fluids? bottle breast cup
- Are they independent with holding their cup or bottle? Yes No
- Do they have a history of reflux? Yes No
- Do they gag or cough during feedings? Yes No

Oral hygiene:

- Do they tolerate having their teeth/gums being cleaned or brushed? Yes No
- Do they use a pacifier? Yes No
- Do they suck their thumb? Yes No

Toileting:

- Do they tolerate diaper changes? Yes No
- Do they have a history of constipation? Yes No

Dressing:

- Do they tolerate their clothing being removed? Yes No
- Do they tolerate their clothing being put on? Yes No

Transitions:

- Do they tolerate changes in routine? Yes No
- If no, describe their response to changes in routine: ____________________________

  ____

Sleep:

- Do they fall asleep easily? Yes No
- Do they stay asleep through the night? Yes No
- Do they wake easily and seem rested? Yes No