

***“Creating the best life for all children”***

**Beavercreek ○ Miamisburg ○ Red Bank Road ○ West Chester ○ Western Hills**

**abcpediatrictherapy.com**

**Parent Questionnaire for OT Feeding Evaluations**

**Please return a printed copy or return by email**

Child’s Name: Click or tap here to enter text.

Date of Birth: Click or tap to enter a date.

Respondent and relationship to child: Click or tap here to enter text.

Child’s weight: Click or tap here to enter text.

Percentile rank for weight: Click or tap here to enter text.

Who does the child reside with? Click or tap here to enter text.

Background History:

Vision:

Have they been screened in the last year? [ ] Yes [ ] No

Date of last screening: Click or tap to enter a date.

Wears glasses: [ ] Yes [ ] No

Vision concerns: Click or tap here to enter text.

Name of vision clinic or doctor: Click or tap here to enter text.

Hearing:

Have they been screened in the last year? [ ] Yes [ ] No

Date of last screening: Click or tap to enter a date.

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: Click or tap here to enter text.

Please list any diagnosis your child may have: Click or tap here to enter text.

Please list the hospitalizations/surgeries: Click or tap here to enter text.

List your child’s current medications: Click or tap here to enter text.

What are your primary concerns regarding your child’s feeding? Click or tap here to enter text.

List any additional concerns not related to feeding: Click or tap here to enter text.

Food allergies: [ ] None [ ] Yes, please list Click or tap here to enter text.

Is the child on a special diet plan? [ ] Yes Click or tap here to enter text. [ ] No

Preferred food list (foods your child finds pleasurable or easiest to eat: Click or tap here to enter text.

Describe a typical day of eating look from a.m. to p.m.: Click or tap here to enter text.

List foods they avoid, refuse or find difficult to eat: Click or tap here to enter text.

Fluids they drink:

[ ] Breastmilk [ ] Formula [ ] Milk [ ] Juice [ ] Supplemental Nutritional Drink

How do they get their fluids?

[ ] Breast [ ] Bottle [ ] Sippy Cup [ ] Straw Cup [ ] Open Cup

Do they have a history of reflux? [ ] Yes [ ] No

Do they gag or cough during feedings? [ ] Yes [ ] No

Do they vomit during feedings? [ ] Yes [ ] No

Indicate where your child is fed: Indicate where your child is fed:

[ ] High Chair [ ] Booster Chair [ ] Standard Chair [ ] Other: Click or tap here to enter text.

Self-Care Skills:

Feeding:

What do they use with when feeding, check all that apply?

[ ] Fork [ ] Spoon [ ] Knife [ ] Cup

Do they use a spoon and/or fork independently? [ ] Yes [ ] No

Are they independent with holding their cup or bottle? [ ] 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 Click or tap here to enter text.

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