

***“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