Rady Children's Hospital San Diego

Rady Children's Hospital – San Diego
3020 Children's Way
San Diego, CA 92123-4282

DTF622

PATIENT INFORMATION

Name: ______________________________
MR#: ______________ Finance: ___________
DOB: ______________________________
MD: ______________________________

Occupational Therapy Feeding Evaluation Questionnaire

Date: _______________

Has your child ever seen another **specialist** (such as a gastroenterologist, nutritionist or feeding therapist) for feeding difficulties? Yes No

If yes, specify: ______________________________

Does the child have any **food allergies** or **intolerances**? Yes No

If yes, describe: ______________________________

Has your child ever had a **dysphagia or upper gastrointestinal tract study**? Yes No

If yes, where? ____________________ When? ____________________

Results: ______________________________

Has a professional ever given your child a specific **diagnosis**? (circle all that apply)

Bronchopulmonary dysplasia	Hearing problems
Cerebral palsy	Hydrocephalus
Chronic lung disease	Prematurity
Cleft lip/palate	Seizure disorder
Congenital heart disease	Tracheo/laryngo malacia
Developmental delay	Tracheostomy
Down Syndrome	Vision problems
Failure To Thrive/poor weight gain	Vocal cord paralysis/paresis

Other: ______________________________

Has your child ever been **hospitalized** or had any **surgical procedures**? (circle all that apply)

Allergies	Gastrostomy
Asthma	Nissen fundoplication
Bronchitis	Pneumonia
Dehydration	PE tubes
Failure to thrive	RSV
Gastroesophageal reflux	Tonsillectomy/adenectomy

Other: ______________________________

Does your child exhibit any of the following? (circle all that apply)

Difficulty with sucking	Choking
Gagging	Difficulty with chewing
Vomiting with meals	Coughing
Teeth Grinding	Hypersensitivity
Drooling	Other: ____________________

Does your child exhibit any of the following behaviors during mealtimes? (circle all that apply)

Crying	Holding food in mouth
Spitting	Turning away
Throwing food	Pushing food/utensils away
Vomiting	Focusing on toys/television during mealtimes

Other: ______________________________

What food does your child currently take? What is his/her **response to these foods**?

Food	No Difficulty	Gagging	Choking	Coughing	Vomiting	Congestion	Wet Voice
Formula / Breastmilk							
Baby Food (Stage 1 or 2)							
Lumpy Baby Food (Stage 3)							
Soft Chewable Solids (pasta, canned fruit, cooked vegetables)							
Hard Chewable Solids (cookies, crackers)							
Chewy Foods (meats)							

What are some of your child's **preferred foods**? ____

____

What are some of your child's **non-preferred foods**? ____

____

Describe a **typical mealtime** (Where seated, typical routine, duration of meal) __________________

____

Please provide any other **concerns** you may have about feeding: ____________________________

____

____

For tube-fed children only

Which type of tube does your child have: gastrostomy tube nasogastric tube nasojejunal tube

How does your child receive his/her feedings:

Continuous feed: _________ ml / oz in ________ hours
Beginning time: ________ Ending time: ________
Beginning time: ________ Ending time: ________

Bolus feed: _____ ml / oz per feeding
Given at ________, ________, ________, ________, ________, ________, ________