

# PEDIATRIC FEEDING TEAM QUESTIONNAIRE

SPEECH/LANGUAGE PATHOLOGIST  
OFFICE OF SPECIAL NEEDS AND SERVICES  
1 JARRETT WHITE ROAD  
TRIPLER ARMY MEDICAL CENTER  
HAWAII 96859-5000 PEDS-EFMP  
TEL: (808) 433-2901  
Lorna.K.Hu@us.army.mil

The following questionnaire is intended to provide information on your child, so that we can better understand your concerns and needs. Your answers will be regarded as confidential information, and will be used by the team to evaluate your child. If you need more space to answer the questions completely, please feel free to attach extra sheets of paper. If you have any questions, please contact Lorna Hu, SLP at 433-2901. Thank You.



## IDENTIFICATION:

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age (in months): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip: \_\_\_\_\_

Parent/ Guardian: Indicate your type of parent status (Natural, Adopted, Step, Legal Guardian, or Other)

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Explain in your own words your concerns about your child's feeding or swallowing difficulties. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**SPONSOR INFORMATION:**

Name: \_\_\_\_\_

Last 4 SSN: \_\_\_\_\_

Status: (active duty/ retired): \_\_\_\_\_ Branch: \_\_\_\_\_

Duty Phone: \_\_\_\_\_

Tricare: \_\_\_\_ Yes \_\_\_\_ No

**SPOUSE INFORMATION:**

Employer: \_\_\_\_\_ Work No. \_\_\_\_\_

Private Insurance: \_\_\_\_\_

**OTHERS LIVING IN THE SAME HOUSEHOLD WITH THE CHILD:**

Name	Relationship to Child	Age (if child)	List Medical/Developmental/Social Problems, if any.

Please check the areas that need assistance (in order of importance).

Relocation/ Hawaii \_\_\_\_\_

WIC \_\_\_\_\_

Time off for child's illness \_\_\_\_\_

Financial \_\_\_\_\_

Duty/ Deployment \_\_\_\_\_

Alcohol \_\_\_\_\_

Housing/ Living Conditions \_\_\_\_\_

Mental Health/ Counseling \_\_\_\_\_

Marriage/ Spouse \_\_\_\_\_

Social Supports \_\_\_\_\_

Children/ Childcare \_\_\_\_\_

Other \_\_\_\_\_

Child Support \_\_\_\_\_

No Needs \_\_\_\_\_

**MEDICAL INFORMATION:**

Medical Diagnosis (if any):		
Current Medical Problems (List):		
1.		
2.		
3.		
Any medication your child is taking:		
Surgeries:		
Child's birth weight:	Birth Length:	Head Size:
Problems during pregnancy:		
Full Term: Yes _____ No _____		
How long was your child hospitalized after birth:		
List problems at that time:		

**FEEDING ABILITY:**

**A. SUCKING**

	YES	NO
1. Can your child suck?		
- From a bottle?		
- From breast?		
2. Does your child choke when sucking?		
3. Could your child suck at an earlier age and now has problems?		
4. Which position (or positions) is easiest for sucking?		
5. Does your child do any of the following when sucking:		

- Makes a fist?		
- Grasps for a bottle?		
- Closes eyes?		
Other:		
6. Can your child suck through a straw?		

## B. SWALLOWING

	YES	NO
1. Can your child swallow liquids?		
2. Is there any difference in the way your child swallows thin or thick liquids?		
3. Can your child swallow solids?		
4. What food can your child swallow most easily?		
5. What foods are difficult to swallow?		
6. Is drooling a problem?		

## C. BITING

	YES	NO
1. Can your child bite?		
2. Does your child bite the spoon		
3. Can your child open his mouth voluntarily after biting?		

## D. CHEWING

	YES	NO
1. What foods does your child chew?		
2. Does your child push his tongue out of his/her mouth when eating?		
3. Does your child suck food rather than chew?		

## E. EATING HABITS

	YES	NO
1. Can your child take his hands or fingers to his/her mouth?		
2. Does your child suck his fingers, thumb, or fist?		
3. Does your child mouth toys and other objects?		
4. Is the face and/or mouth region sensitive to touch?		
5. Does your child finger-feed?		
At what age did he/she begin?		
Which foods?		

6. Do you spoon feed your child?					
7. Does your child spoon feed him/ herself?					
8. Does your child use a fork and/or knife?					
At what age did your child begin?					
9. Does your child drink from a cup?					
At what age did your child begin?					
		YES	NO		
He / She uses:	1 handle			1 hand	
	2 handles			2 hands	
10. Has your child been completely weaned from the bottle?					
If not, how often do you give him / her one?					
11. Does your child sit during feeding?					
Where?					
12. Who usually feeds your child?					
13. In what room does your child usually eat?					
14. Does your child prefer food that are:					
		Sweet			
		Salty			
		Sour			
		Spicy			
		Hot			
		Cold			

## F. COMMUNICATION

	YES	NO
1. How much does your child vocalize?		
About average?		
Very little?		
Very much?		
2. What kinds of sounds does your child make?		
3. Does your child imitate the sounds you make?		
4. Does your child say any words?		
How many?		
What are they?		
5. How does your child tell you when he / she is hungry?		

## G. NUTRITION

	YES	NO
1. Does your child eat a variety of foods (milk, meat, fruit/vegetable, and cereal/grain)?		

If no, describe:		
2. Does your child take a special formula or diet?		
Describe:		
Amounts:		
3. How much milk and/ or juice does your child drink in one day? Bottle/ Cup?		
4. Does your child take a vitamin and/ or mineral supplement? If yes, how often? Which?		
5. Has anyone ever told you your child is anemic? Explain:		
6. Does your child have any food allergies or intolerance?		
7. Does your child have a problem with vomiting, regurgitation?		
8. Is your child fed with a nasogastric or gastrostomy tube?		
9. Does your child have problems with constipation or diarrhea? Describe:		
10. Does your child take medications a majority of the time? Please list:		
11. Does your child have a history of rapid weight gain or weight loss? Explain:		
12. Do you feel your child is overweight? Underweight?		
13. Is he/ she growing well? If not, explain:		
14. List any problems/ concerns you have regarding your child's diet:		
15. Have you ever seen a nutritionist or dietitian regarding these problems?		
16. Has your child been seen by a dentist? Are there any problems? Explain:		

What would you like accomplished during this evaluation visit?

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