GOLISANO CHILDREN'S HOSPITAL

Developmental and Behavioral Pediatrics

Feeding Disorders Program New Patient Questionnaire

Dear Family,

To get ready for your child's feeding evaluation, we need your help to do two things:

1. **Get information from your child's pediatrician** - Please call your child's doctor and ask them for (1) your child's growth charts, and (2) any labwork your child has had done. Please bring these to your appointment, or your doctor can fax these to (585) 275-3366, Attention: Feeding Team.

2. **Complete the following form** - This questionnaire is a chance for us to learn about your child before your visit. It should be completed by the person who takes care of your child most of the time. This will help us to make the visit go smoothly. There are no right or wrong answers. Answer each question to the best of your ability. If you have questions or want help filling out this form, please call Lisa Lang at (585) 275-2986. Please bring the completed form to your child's appointment.

Your Visit Schedule

First visit: You will come, without your child, to discuss your child's feeding problems and help us get a better understanding of what your concerns are.

Second visit: You will bring your child to the visit, and we will observe him/her eating a snack. Please bring a few items that he/she likes, and few items you would like him/her to eat. You can also bring preferred cups or plates, as needed. At the end of this visit, we will discuss therapy options.

Thank you,

The Feeding Team

601 Elmwood Avenue · Box 278877 · Rochester, NY 14642
585.275.2986 · 585.275.3366 fax · www.golisano.urmc.edu/dbp

Child's name _____ Child's date of birth _____

Child's address _____ Date form completed _____

Persons Completing Form

Name	Relationship to child	Does the child live with you?	Phone numbers
	☐ Biologic parent ☐ Foster/adoptive parent ☐ Relative ☐ Guardian ☐ Other	☐ Yes ☐ No	(H) (C) (W)
	☐ Biologic parent ☐ Foster/adoptive parent ☐ Relative ☐ Guardian ☐ Other	☐ Yes ☐ No	(H) (C) (W)
Parent/Guardian Marital Status	☐ Married ☐ Divorced ☐ Separated ☐ Unmarried ☐ Widowed		

Home Information

Please list all adults and children who live at home with this child.

Name	Age	Relationship to child	Occupation or grade in school	Has this person ever been seen in Kirch/DBP?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Are there any living arrangements (for example, shared custody or foster care), custody issues, parental disagreement about care, or orders of protection that we should be aware of?

Daycare/School Information

Current daycare	
Daycare address	
Daycare phone number	
Current school/preschool	
School address	
School phone number	

Feeding/Eating Information

Please describe your **concerns** about your child's eating.
What are your **goals** for your child's eating?

Health History

Are any of the following health concerns a problem for the child currently or were a past concern?

Concern	Currently	Never	In the past
Developmental delays (ASD, ADHD, anxiety)	☐	☐	☐
Head injury, seizures, or other brain problems	☐	☐	☐
Vision problems	☐	☐	☐
Ear problems (infections, hearing, or other)	☐	☐	☐
Dental problems	☐	☐	☐
Heart conditions	☐	☐	☐
Asthma, needs oxygen, or other lung problems	☐	☐	☐
Nausea or vomiting	☐	☐	☐
Gastroesophageal Reflux (GERD)	☐	☐	☐
Eosinophillic Esophagitis (EoE)	☐	☐	☐
Delayed gastric emptying	☐	☐	☐
Diarrhea (loose, watery stools)	☐	☐	☐
Constipation (hard, painful stools)	☐	☐	☐
Stomach/abdominal pain	☐	☐	☐
Kidney/bladder problems	☐	☐	☐
Anemia (low blood counts)	☐	☐	☐
Skin problems	☐	☐	☐
Allergies to food or medicine	☐	☐	☐
Genetic disorder	☐	☐	☐
Health concern not listed above	☐	☐	☐

If you selected any of the boxes above, please describe…

Please list any additional developmental concerns.

Has your child ever had any procedures to evaluate feeding, swallowing, or GI function?

☐ X-ray ☐ Swallow study ☐ Upper GI ☐ Endoscopy ☐ Gastric emptying study ☐ Abdominal x-ray

☐ Other:

Has your child ever had tube feedings? ☐ Yes ☐ No

If yes, what type?

☐ NG (nasogastric) ☐ G-tube ☐ Gastrostomy-Jejunostomy (GJ tube)

Please list the dates the tube was placed and/or removed:

Does your child currently use tube feedings? ☐ Yes ☐ No

If yes, please complete the following:

Name of formula	
Type of feedings	☐ Bolus ☐ Continuous
Amount per hour (rate)	
Total volume given per feeding each day	
Total volume per day	
Vomiting or other problems during tube feedings?	☐ No ☐ Yes If yes, please list:

Schedule:

Time	**Amount**

Labor and Delivery

Birth mother's age at birth of child _____ Birth father's age at birth of child _____

Birth weight _____ Birth length _____ Birth head circumference _____

What was the length of the pregnancy (gestational age)? _____ months or _____ weeks

Was this child…	☐ Single birth ☐ One of twins ☐ One of triplets ☐ Other multiple
Was this child born by…	☐ Vaginal delivery ☐ Cesarean section
Please describe any labor/delivery complications.	
Was your child admitted to the Special Care Nursery or NICU (neonatal ICU)?	☐ Yes ☐ No ☐ Unsure
If "Yes", please describe…	
How old was your child when discharged from the NICU?	

Feeding History

How was your child fed during infancy?	☐ Breast ☐ Bottle ☐ Both ☐ Not fed by mouth
Did you child have problems with breast or bottle feeding?	☐ Yes ☐ No ☐ Unsure
If "Yes", please describe…	
Age when baby foods were given	
Age when table foods were given	
How did your child respond to these foods?	
At what age did you first notice your child had a feeding problem?	

Allergy and Nutrition

Please list any food allergies.	
Please list any food restrictions.	
Please list any vitamins/supplements you give your child.	

Feeding Skills and Abilities

Please select any items that are a problem during feeding:

☐ Gagging ☐ Coughing ☐ Problems drinking ☐ Loses food/liquid from mouth ☐ Trouble chewing ☐ Tongue thrust
☐ Problems swallowing ☐ Drooling ☐ Problems moving tongue side to side ☐ Poor suck ☐ Poor lip closure
☐ Problems biting off food

Do the above problems occur with ☐ All foods ☐ Certain types/textures

Has your child ever needed thickened liquids?	☐ Yes ☐ No
Has your child ever needed foods to be pureed?	☐ Yes ☐ No
Are you worried about aspiration (food/liquid going into the child's lungs)?	☐ Yes ☐ No
Has your child ever choked and needed the Heimlich?	☐ Yes ☐ No ☐ Unsure

Self-Feeding

Which of the following describes your child's feeding?

☐ Bottle or breast fed only ☐ Parent spoon-feeds child ☐ Child uses his/her fingers to eat
☐ Child feeds him/herself, but needs adult help ☐ Child feeds him/herself independently

Tell us about the following utensils your child uses.

Utensil	Does not use	Uses, with adult help	Uses independently
Spoon	☐	☐	☐
Fork	☐	☐	☐
Straw	☐	☐	☐
Open cup	☐	☐	☐
Sippy cup	☐	☐	☐
Baby bottle	☐	☐	☐
Water bottle	☐	☐	☐

Current Feeding Routines

What does your child sit in to eat? (Select all that apply)	☐ High chair ☐ Booster seat ☐ Regular table and chair ☐ Child's table and chair ☐ On adult lap ☐ Lying down ☐ Other:
Where in the house does he/she sit?	☐ Kitchen ☐ Dining room ☐ Living room ☐ Bedroom ☐ In front of TV/computer ☐ Walking around the house ☐ Other:
Who does your child eat with?	☐ By him/herself ☐ Siblings ☐ Peers ☐ Other family members
How long does your child sit for a usual meal or snack?	
Does your child have a usual meal and snack schedule?	☐ Yes ☐ No

Please list the most typical times.

Meal/snack	Time	Location (home, school, etc.)	Food/drink typically offered

Does your child eat better in different places or with different people?	☐ Yes ☐ No

If yes, please describe…

Family members:

School/daycare:

Restaurants:

Parties/sleepovers:

Food Preference Checklist

Child's name _____

How would you rate your child's appetite on a scale of 1 (poor) to 10 (eats too much)? _____

Please select all foods your child <u>currently eats</u> and label any specific brands.

Starches

- ☐ Bread
- ☐ Oatmeal
- ☐ French fries
- ☐ Mashed potatoes
- ☐ Spaghetti
- ☐ Rice
- ☐ Noodles
- ☐ Corn
- ☐ Baked potatoes
- ☐ Waffles
- ☐ Pancakes
- ☐ Cereal (list brands)
- ☐ French toast
- ☐ Muffins
- ☐ Macaroni and cheese

Fruits

- ☐ Orange juice
- ☐ Apple juice
- ☐ Grape juice
- ☐ Watermelon
- ☐ Raisins
- ☐ Peaches
- ☐ Pears
- ☐ Pineapple
- ☐ Oranges
- ☐ Bananas
- ☐ Strawberries
- ☐ Berries
- ☐ Apples
- ☐ Applesauce
- ☐ Grapes

Vegetables

- ☐ Green beans
- ☐ Cucumber
- ☐ Peas
- ☐ Spinach
- ☐ Broccoli
- ☐ Lettuce/salad
- ☐ Tomatoes
- ☐ Carrots
- ☐ Sweet potatoes

Milk/Dairy

- ☐ Soy/almond milk
- ☐ Cheese
- ☐ Pudding
- ☐ Ice cream
- ☐ Milk (list type)
- ☐ Chocolate/flavored milk
- ☐ Yogurt (list type)

Meat/Protein

- ☐ Chicken
- ☐ Chicken nuggets
- ☐ Sausage
- ☐ Pork
- ☐ Other:
- ☐ Fish
- ☐ Fish sticks
- ☐ Ham
- ☐ Nuts
- ☐ Eggs
- ☐ Hamburger
- ☐ Peanut butter
- ☐ Roast beef
- ☐ Steak
- ☐ Turkey
- ☐ Hot dogs

Mixed Textures

- ☐ Pasta with sauce
- ☐ Tacos/burritos
- ☐ Pizza
- ☐ Casseroles
- ☐ Peanut butter & jelly
- ☐ Grilled cheese

Extras

- ☐ Margarine
- ☐ Salad dressing
- ☐ Other:
- ☐ Syrup
- ☐ Jelly
- ☐ Mayonnaise
- ☐ Mustard
- ☐ Cream cheese
- ☐ Ketchup

Snacks

- ☐ Cookies
- ☐ Chips
- ☐ Goldfish
- ☐ Pretzels
- ☐ Crackers
- ☐ Water
- ☐ Soda
- ☐ Pop Tarts
- ☐ Kool-Aid

Please list any foods your child used to eat but doesn't eat anymore (within the last 6 months).

How much (in ounces) of the following liquids does your child drink each day?

Milk	Formula	Soda	Juice
Breastmilk	Water	Other	

Food Selectivity Concerns

What textures does your child like best? (select all that apply)

☐ Dry ☐ Crunchy ☐ Soft (i.e. pasta) ☐ Wet (i.e. fruit) ☐ Purees (i.e. applesauce) ☐ Single texture (i.e. banana)
☐ Mixed texture (i.e. pizza, spaghetti, mac & cheese) ☐ Other:

What flavors does your child like best? (select all that apply)

☐ Bland ☐ Salty ☐ Sweet ☐ Spicy ☐ Sour ☐ Bitter ☐ Other:

Brand or container preferences	
Temperature, shape, or color preferences	
Food preparation preferences	
Specific utensils or cups needed	

Mealtime Behavior

Please select all of the behaviors your child shows during mealtimes.

☐ Screams/cries ☐ Spits food out ☐ Pushes food away ☐ Turns head away ☐ Keeps mouth shut ☐ Tantrums
☐ Overstuffs mouth ☐ Leaves the table ☐ Holds food in mouth (doesn't swallow) ☐ Eats too slow ☐ Eats too fast
☐ Gags/vomits ☐ Other:

When you offer a new food, at what point does your child begin to get upset?

☐ When we talk about it ☐ When he/she sees the food ☐ When he/she smells the food ☐ When food is put on the table
☐ When food is put on his/her plate ☐ When he/she touches it ☐ When he/she tastes it
☐ Other:

Behavior Management

Please select all of the things you have tried to get your child to eat.

☐ Toys ☐ Remote privileges ☐ Cook only preferred foods ☐ Time out ☐ TV ☐ Force food in mouth
☐ Offer favorite toys or activities ☐ Talking/singing ☐ Rewards ☐ Mix/sneak non-preferred foods into favorites

Has your child received feeding therapy before?	☐ Yes ☐ No ☐ Unsure
If yes, where and what was the therapist's name?	
Does your child currently receive any therapies?	☐ Yes ☐ No ☐ Unsure

Type	Receiving?	Therapist name	Agency/location	Is therapist working on feeding?
Speech	☐ Yes ☐ No			☐ Yes ☐ No
Occupational therapy	☐ Yes ☐ No			☐ Yes ☐ No
Physical therapy	☐ Yes ☐ No			☐ Yes ☐ No
Nutrition	☐ Yes ☐ No			☐ Yes ☐ No
Special education	☐ Yes ☐ No			☐ Yes ☐ No
Psychologist	☐ Yes ☐ No			☐ Yes ☐ No
Other:	☐ Yes ☐ No			☐ Yes ☐ No

BAMBI (Brief Autism Mealtime Behavior Inventory)

Lukens and Linscheid, 2008

Child's Name_____ **Time Point:**

Below is an 18 item questionnaire related to a variety of food and meal specific child behaviors. Based on your child's mealtime behaviors **over the past 6 months**, rate the following items according to how often each behavior is likely to occur **when less preferred or new foods are offered**. Rate the items using the following scale:

Never/Rarely	Seldom	Occasionally	Often	At Almost Every Meal
1	2	3	4	5

In addition to the numerical rating, circle YES if you think an item is a problem for you and your child or NO if you think it is not a problem. Please indicate both numerical ranking and yes/no response.

1.	My child cries or screams during mealtimes.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
2.	My child turns his/her face or body away from food.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
3.	My child remains seated at the table until the meal is finished.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
4.	My child expels (spits out) food that he/she has eaten.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
5.	My child is aggressive during mealtimes (hitting, kicking, scratching others).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
6.	My child displays self-injurious behavior during mealtimes (hitting self, biting self).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
7.	My child is disruptive during mealtimes (pushing/throwing utensils, food).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
8.	My child closes his/her mouth tightly when food is presented.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
9.	My child is flexible about mealtime routines (e.g., times for meals, seating arrangements, place settings).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
10.	My child is willing to try new foods.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
11.	My child dislikes certain foods and won't eat them.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
12.	My child refuses to eat foods that require a lot of chewing (e.g., eats only soft or pureed foods).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
13.	My child prefers the same foods at each meal.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
14.	My child prefers "crunchy" foods (e.g., snacks, crackers).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
15.	My child accepts or prefers a variety of foods.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
16.	My child prefers to have food served in a particular way.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
17.	My child prefers only sweet foods (e.g., candy, sugary cereals).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO
18.	My child prefers food prepared in a particular way (e.g., eats mostly fried foods, cold cereals, raw vegetables).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ YES ☐ NO