Intensive Feeding Program Questionnaire

Family Questionnaire

Today's date:_____

Child's name: _____ date of birth: _____

Family Information

Primary care giver(s)

Name: _____ relationship to child: _____

Name: _____ relationship to child: _____

Other children/siblings in the home (*include ages*): _____

_____

Other caretakers (other than parents) (*please describe*) _____

_____

Does your child attend daycare, preschool or school? (*please describe*)

_____

_____

_____

Health Care Provider Information

Primary medical care provider: _____

Phone: _____ email: _____

Feeding therapist: _____

Phone: _____ email: _____

Dietician: _____

Phone: _____ email: _____

Home health care company:_____

Phone: _____ email: _____

Medical History

Was your child born at full term? _____

Was your child born early?_____

What was your child's birthweight? _____

Are you giving your child any medicines, herbs or vitamins? (If so, *please list*): _____

_____

_____

Does your child have any food allergies or food sensitivities? (If so, *please list*):_____

_____

_____

Does your child have other allergies, i.e., medications, latex, etc.? (If so, *please list*): _____

_____

_____

Has your child had a swallow study? (Date, place and results): _____

_____

_____

Your child's medical history gives us an idea of what your child has experienced in the past. Has your child had any of these symptoms? Please check those that apply past and present.

Does your child have:			**If yes, please briefly describe:**
Vomiting?	❑ No	❑ Past	❑ Present
Diarrhea?	❑ No	❑ Past	❑ Present
Constipation?	❑ No	❑ Past	❑ Present
Dental Concerns?	❑ No	❑ Past	❑ Present
Trouble sleeping?	❑ No	❑ Past	❑ Present
Gastroesophageal reflux?	❑ No	❑ Past	❑ Present
Swallowing difficulties?	❑ No	❑ Past	❑ Present
Pain or discomfort during feeding?	❑ No	❑ Past	❑ Present
Is your child frequently sick	❑ No	❑ Past	❑ Present

Any other significant medical history?

_____

_____

Do you have any concerns about your child's overall development or behavior**?** (If so, *please describe*):

_____

_____

Nutrition History

When were you first aware that your child had feeding difficulties? _____

_____

When was your child's first feeding tube placed? _____

_____

What type of tube does your child currently use? _____

_____

What was the primary reason(s) for the tube placement? _____

_____

What formula or home blended diet do you currently use for tube feedings? _____

_____

Do you use a recipe? (If so, *please describe*): _____

_____

_____

Does your child have a daily goal for tube feeding amounts? (If so, *please describe*): _____

_____

Please write out your child's tube feeding schedule, including times and amounts of water:

_____

_____

_____

_____

Are there any foods that your family avoids because of religious, social or cultural reasons? _____

_____

Please complete the attached food record form for 3 days including tube and oral intake.

Family Point of View

Please circle words that describe your child's temperament or personality: (*Please circle all that apply*)

Shy Outgoing Adaptable Flexible Strong-willed Active Quiet Distractible Sensitive Easygoing Stubborn Rigid Worrier Aggressive

Please review the following questions: *(write out answers or bring your thoughts to discuss during your child's first appointment.*)

Are there signs that your child is ready to transition to oral feeding? *(Please share with us why you think your child is ready for this.)* _____

_____

Does your child show uncomfortable feelings around feeding? Have you found ways to help settle or calm your child in response to these feelings? _____

_____

Does your child have difficulties with change in routine? What have you found helpful in preparing your child for change? _____

_____

Intensive feeding therapy is hard work. What motivates your child? For instance, does your child respond best to praise, a toy, music, video, or collecting stickers/points for rewards? *(Please describe.)*

_____

On a scale of 1 to 10, with 10 being most difficult, how frustrated/anxious do you feel about your child's eating problems? _____

_____

Do you have any special needs related to your child's care that would help us better evaluate your child's feeding issues? _____

_____

As members of your child's treatment team, it is helpful to know about any major stressors that your family is experiencing now or in the past year. We are available to talk about these, or any other concerns, in order to provide increased support, information or referral for other resources.

Thank you,
The Intensive Feeding Team
206-987-2329

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