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Supplemental Sensory Feeding Evaluation
Intake Questionnaire

PLEASE BRING THIS WITH YOU FOR YOUR CHILD'S EVALUATION

Health of Infant at Birth: (check all that apply)

- ☐ No issues
- ☐ Jaundice
- ☐ Cardiac issues
- ☐ Gastroschisis
- ☐ Breathing difficulty
- ☐ Brain bleed
- ☐ Seizures
- ☐ NAS-neonatal abstinence syndrome
- ☐ Other:_____

Describe your child's sleep patterns:

☐ Lengthy/multiple night wakings ☐ Snoring ☐ Mouth breathing

☐ Sleeps through the night ☐ Other: _____

Where do they sleep?

☐ Own bed ☐ Crib ☐ Family bed

Describe your child's voice quality:

☐ Breathy ☐ Shrill ☐ Hypernasal ☐ Gurgly ☐ Weak ☐ Hyponasal ☐ Normal

Pitch of Voice:

☐ Normal ☐ Too High ☐ Too Low

Volume:

☐ Normal ☐ Weak ☐ Loud

Does your child use a pacifier? ☐ Yes ☐ No

Does your child drool?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Constantly

Sensory: (please check yes or no for each statement)

My child dislikes being messy.	☐ Yes	☐ No
My child is a "picky eater".	☐ Yes	☐ No
My child seems to constantly be "on the go", having difficulty sitting still.	☐ Yes	☐ No
My child becomes upset with brushing teeth/hair, bathing, dressing/undressing.	☐ Yes	☐ No

My child "melts-down" when there is a change in routine, or something unplanned comes up.	☐ Yes	☐ No
My child becomes easily frustrated and frequently has tantrums.	☐ Yes	☐ No
My child appears not to "tune-in" to what I say, even though his/her hearing is fine.	☐ Yes	☐ No

What are your child's preferences with feeding?

Preferred food temperatures ☐ Warm ☐ Cold

Preferred liquid temperatures ☐ Warm ☐ Cold

Location for feeding:

☐ One place (Where?) _____ ☐ Several places

Was your child breastfed?

☐Yes ☐No

If yes, until what age? _____

Were there any problems/difficulties? (please describe)

Is/Was your child bottle fed?

☐Yes ☐No

If yes, until what age? _____

Using what type of bottle/nipple? _____

Were there any problems/difficulties? (please describe)

Is/Was your child fed through a feeding tube?

☐Yes ☐No

What type of tube?

☐NG ☐OG ☐NJ ☐ND

If yes, until what age? _____

At what age was solid food introduced? _____

Did your child easily transition to solid foods? ☐ Yes ☐ No

How do you know when your child is hungry?

How do you know when your child is full?

Appetite: ☐ Good ☐ Inconsistent ☐ Poor

Has your child ever turned blue during or after a feeding? ☐ Yes ☐ No

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Mealtime Routine

Where do meals typically occur? (i.e. Kitchen table, sofa, etc.)

Who is typically present during mealtimes? Do they eat with the child?

How many times a day does your child eat?

What time do meals and snacks occur? (i.e. 8:00am breakfast, 10:30am snack, etc.)

Of these meals and snacks, which is the most problematic meal/time of day?

Is anything simultaneously occurring during meals? (i.e. TV, music, toys, iPad, etc.)

How is the child positioned during meals? (i.e. booster seat, highchair, chair)

How long will child remain seated during meals?

How long do typical meals last?

What are your child's favorite foods/drinks?

What foods/drinks are more difficult for your child to eat?

How are meals or food presented (i.e. family style with food on table, food placed on plate)?

Does child eat the same meal as parents/other family members?

When feeding, does child use: (check all that apply)

☐ Hands	☐ Open cup
☐ Plate	☐ Sippy cup
☐ Spoon	☐ Bottle
☐ Fork	☐ Straw
☐ Knife	☐ Caregiver feeds child

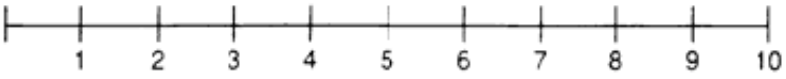
Is there any history of caregivers/family having similar feeding or sensory issues (past or present)? (Please describe)

What seems to help (or not help) your child during mealtimes?

Is there anything else about your child's feeding that you would like us to know?

How would you rate caregiver(s)' stress level regarding feeding and mealtimes? (Feel free to rate more than one caregiver)

Not at all concerned or stressed



Extremely stressed

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Please check those that apply to your child:

- ☐ Coughing during /after feeds
- ☐ Choking during meal
- ☐ Food/liquid coming out of nose
- ☐ Difficulty swallowing
- ☐ Trouble breathing during feeding
- ☐ Spitting food out
- ☐ Fussing/crying during meals
- ☐ Head turning to avoid feeding
- ☐ Facial grimace
- ☐ Exhibits or complains of pain/discomfort with feeds
- ☐ Postural changes during feeding:
  - ☐ stiffening ☐ hyperextending (arching)
- ☐ Gagging during meal; after feeding (at least 30 min)
- ☐ Eats too little ☐ Eats too much
- ☐ Reflux during / after meals
- ☐ Falling asleep during feeding
- ☐ Color change (becomes pale, turns red or blue)
- ☐ Vomiting during / after meals
- ☐ Accepts food/drink in mouth, but does not swallow
- ☐ Refuses oral feeding
- ☐ Difficulty with weight gain
- ☐ Noisy breathing:(during, before or after)
- ☐ Gurgly voice quality:(during, before or after)

Does your child have behavior difficulties during mealtimes? (check all that apply):

☐ Throws food ☐ Messy eater ☐ Spits food ☐ Refuses to eat
☐ Cries, screams ☐ Takes food from other's plate ☐ Leaves table before finished

Please bring foods that your child likes to eat, items that may be challenging or not preferred, and this questionnaire to your appointment. As age appropriate, bring liquid, soft/puree food, something that must be chewed (ex: fruit cup) and regular table food item (cracker, cookie, sandwich). If possible, please bring bottles/cups and utensils your child typically uses, to make your child more comfortable during the evaluation.

I acknowledge that I have received a copy of the *Welcome to Pediatric Therapy Services* orientation packet.

Caregiver Signature:_____ **Date:**_____

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FOOD LOG

*Please track your child's food and drink intake over a period of **3 days**

Date	Time of Day & Duration	Food/ Drink Item	Amount	Negative Behaviors/Difficulty

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FOOD VARIETY

List all food items that your child currently eats.

Please ★ preferred food items.

Proteins (Meat, beans, nuts, dairy, etc.)	Fruits and Vegetables	Carbohydrates (Breads, crackers, sweets, etc.)