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Feeding Questionnaire
(to be filled out with UF Health CAN Caregiver Questionnaire)

Dear Caregiver:

We are interested in gathering more information about your child's mealtime behavior. We kindly ask that you complete this form and return it as soon as possible. Thank in advance for your time.

Patient's Information		
Last Name:	First Name:	Date of Birth:
Current Height:	Current Weight:	

Primary Caregiver Information			
Last name:	First Name:	Phone #:	Email:

Describe your child's medical status below as it relates to feeding
Food intolerances:
Special diet:
Allergies to medications:
Allergies to food:
If your child has food allergies, who diagnosed the food allergies and what test(s) did the doctor do?

	Yes	**No**	**Describe**
Tongue clipping	☐	☐	
Tongue/cheek/lip tied	☐	☐	
Other	☐	☐	

Gastrointestinal Symptoms: Check the boxes that describe your child					
Problem	**Yes**	**No**	**Problem**	**Yes**	**No**
Appetite change	☐	☐	Jaundice	☐	☐
Gallbladder disease	☐	☐	Liver disease	☐	☐
Heartburn or reflux	☐	☐	Nausea or vomiting	☐	☐
Inflammatory bowel disease	☐	☐	Vomiting blood or bile	☐	☐
Irritable bowel syndrome	☐	☐	Other	☐	☐

Toileting: Check the boxes that describe your child.					
Does your child	**Yes**	**No**	**Problem**	**Yes**	**No**
take laxatives?	☐	☐	black tarry stools?	☐	☐
withhold stools?	☐	☐	blood in the stools?	☐	☐
How often does your child stool?			Do the stools vary in consistency?	☐	☐

Abdominal Symptoms: Check the boxes that describe your child.			
Does your child:	**Yes**	**No**	**Describe below for the boxes you check.**

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Have abdominal pain?	☐	☐	How long has your child had abdominal pain?	
Does pain improve with treatment?	☐	☐	How long does the pain last?	
Does pain improve after a bowel movement?	☐	☐	What treatments have you used for the pain?	
Does pain improve with a modified diet?	☐	☐	Other:	
Other:	☐	☐		

Other Medical Symptoms: Check the boxes that describe your child.						
	Yes	**No**				
Unexplained fevers	☐	☐	If so, how often?			
Weight loss	☐	☐	If so, over how long?			
Weight gain	☐	☐	If so, over how long?			
Cardiovascular	**Yes**	**No**	**Genitourinary**	**Yes**	**No**	
Heart disease	☐	☐	Blood in urine	☐	☐	
Heart murmur	☐	☐	Pain with urination	☐	☐	
Ear, Nose, Throat	**Yes**	**No**	**Hematology, Lymphatic**	**Yes**	**No**	
Frequent ear infections	☐	☐	Bleeding gums	☐	☐	
Mouth sores	☐	☐	Enlarged lymph nodes	☐	☐	
Sinus problems	☐	☐	Excessive bruising	☐	☐	
Endocrine	**Yes**	**No**	History of anemia	☐	☐	
Diabetes	☐	☐	Nose bleeds	☐	☐	
Growth problems	☐	☐	**Skin**	**Yes**	**No**	
Thyroid problems	☐	☐	Eczema	☐	☐	
Neurologic	**Yes**	**No**	Rashes	☐	☐	
Excessive fussiness or irritability	☐	☐	**Respiratory**	**Yes**	**No**	
Frequent headaches	☐	☐	Asthma, wheezing	☐	☐	
Seizures	☐	☐	Chronic cough	☐	☐	
			Pneumonia	☐	☐	

Has your child had any of the following medical tests?				
Medical Tests	**Yes**	**No**	**Date of Test**	**Results**
Endoscopy	☐	☐		
Colonoscopy	☐	☐		
Food allergies	☐	☐		
Gastric emptying	☐	☐		
Modified barium swallow study	☐	☐		
pH probe	☐	☐		
Other	☐	☐		

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Has your child had any of the following procedures?				
Procedures	**Yes**	**No**	**Dates**	**Comments**
G tube	☐	☐		
G-J tube	☐	☐		
J tube	☐	☐		
Nasal cannula	☐	☐		
OG tube	☐	☐		
Tracheostomy	☐	☐		
Others				

Check the statements that describe your child's feeding behavior.			
☐	Dependent on tube feedings	☐	Dependent on baby/creamy/pureed food
☐	Dependent on liquid (e.g., shakes, formula)	☐	Only eats from certain food groups (e.g., my child only eats starches and some fruits and refuses all vegetables)
☐	Does not eat enough healthy foods	☐	Eats mostly junk/snack foods (e.g., chips, pretzels, fries, cupcakes)
☐	Does not eat any food	☐	Does not drink any liquids
☐	Has problem behavior at meals	☐	Cries and tantrums at meals
☐	Does not swallow food (i.e., holds food in mouth)	☐	Does not swallow liquids (i.e., holds liquid in mouth)
☐	Is not growing properly	☐	Vomits during or between meals
☐	Coughs at meals	☐	Gags at meals
☐	Cannot or does not chew	☐	Spits out food
☐	Spits out liquid	☐	Cannot or does not feed him/herself
☐	Drools more than should for age	☐	Takes unusually small bites
☐	Takes unusually large bites/ stuffs mouth	☐	Only eats when fed by a certain person
☐	Requires a particular routine to drink (e.g., specific plate or cup, specific brand of foods), please describe the routine:	☐	Requires a particular routine to eat (e.g., specific plate or cup, specific brand of foods), please describe the routine:
☐	Eats too much	☐	Drinks too much
☐	Other, please describe:	☐	Other, please describe:

Check the boxes that show how long it takes your child to eat each meal						
Minutes	0-10	11-20	21-30	31-40	41-50	51+
Breakfast						
Lunch						
Dinner						
Snack						

Describe the mealtime environment			
☐	Eats at a scheduled time	☐	Eats as wanted
☐	At table with family	☐	Eats separately
☐	Walks around while eating	☐	Other:

Check the boxes that describe your child's mealtime behavior across food textures. See definitions for each column below.	
Only drinks from bottle	Specify current nipple used:

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Food Type	Does	Can	Never	Can't	Has not	Age (years & months)
Baby food	☐	☐	☐	☐	☐	☐
Creamy food (e.g., yogurt)	☐	☐	☐	☐	☐	☐
Pureed table food	☐	☐	☐	☐	☐	☐
Mashed table food	☐	☐	☐	☐	☐	☐
Chopped table food	☐	☐	☐	☐	☐	☐
Regular table food (e.g., pizza)	☐	☐	☐	☐	☐	☐
Crispy food (e.g., crackers)	☐	☐	☐	☐	☐	☐
Crunchy food (e.g., carrot)	☐	☐	☐	☐	☐	☐
Chewy food (e.g., chicken nugget)	☐	☐	☐	☐	☐	☐

Does =	Your child will eat the food most of the time when you serve it.
Can=	Your child has the skill or ability to eat the food even if he or she does not eat it.
Never=	Your child never or rarely will eat the food when you serve it.
Can't=	your child does not have the skill or ability to eat the food even if he or she is willing to eat it.
Has not=	You have never given this to your child.
Age=	The age of your child when you first gave this texture to him or her.

Check your goals for treatment of your child's feeding behavior.			
☐	Increase the number of different foods my child eats	☐	Increase my child's dependence on liquid
☐	Decrease my child's dependence on tube feedings	☐	Increase my child's acceptance of liquids
☐	Decrease my child's dependence on baby/pureed/creamy food	☐	Decrease problem behavior at meals
☐	Increase swallowing of foods	☐	Increase swallowing of liquids
☐	Decrease weight	☐	Increase my child's self-feeding during meals
☐	Increase weight	☐	Decrease vomiting during or between meals
☐	Decrease coughing at meals	☐	Decrease gagging at meals
☐	Teach my child to chew	☐	Decrease spitting liquid
☐	Decrease spitting food	☐	Other, please describe:
☐	Decrease the duration of my child's meals		

9. If your child has a tube, write down the time, type, rate, volume, and method (e.g., gravity) of each non-oral feed.
Here is an example: **N/A** ☐

7:00 am	G tube	120 ml/hr	60 ml	pump
Time	Type	Rate	Volume	Method

Does your child consume a high-calorie, nutritionally-complete formula or shake (e.g., Pediasure)?	**Yes** ☐	**No** ☐
If your answer is Yes, please fill out the information below:		
Who prescribed the formula? (e.g., dietician):		
Formula Name (e.g., Pediasure):		
Formula Version: (e.g., 1.5, with fiber):		
Flavor (e.g., Vanilla):		
Recipe, if applicable (2 scoops + 8 oz water):		

Check the boxes that indicate which food groups your child eats from.		**If you check a box, estimate how many foods your child consistently eats from that group.**
☐	Fruits	
☐	Grains	
☐	Proteins	
☐	Vegetables	
☐	Junk foods	
☐	Liquids	

Check the boxes to indicate whether your child has or had any of the following problems.					
Problem	**Has**	**Had**	**Problem**	**Has**	**Had**
Aspiration	☐	☐	Difficulty chewing	☐	☐
Penetration	☐	☐	Poor lip control	☐	☐
Clearing throat	☐	☐	Poor suck	☐	☐
Coughing while drinking	☐	☐	Poor tongue control	☐	☐
Coughing while eating	☐	☐	Profuse perspiration	☐	☐
Difficulty swallowing	☐	☐	Tongue thrust	☐	☐
Gagging while drinking	☐	☐	Teeth grinding	☐	☐
Gagging while eating	☐	☐	Other:	☐	☐

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Child Three-Day Food Record

Pick 3 days to write down what you make your child to eat and drink and what your child ate and drank. Write the dates in the column labeled "date." Write down what you made your child in the column labeled "Food Items." The "Yield" is the amount of food that resulted if you pureed or ground the food. In the example below, four chicken nuggets pureed with ½ cup of milk resulted in 1 cup of the chicken nugget-milk mixture. Disregard this column if you do not blend or grind your child's food. Write down how much your child ate or drank in the column labeled "Amount Consumed." Be as specific as possible. Write down the amount your child eats and drinks in volume (e.g., tablespoons, cups) or weight (e.g., grams, ounces). Include brand names and recipes.

Here's an example.			
Date & Time	**Food Item**	**Yield**	**Amount Consumed**
1/14/17, 11:30 am	4 Tyson chicken nuggets, ½ cup whole milk	1 cup	1/3 cup
	Red grapes		3 grapes
1/14/17, 2:30 pm	Pediasure		8 ounces (1 bottle)
1/14/17, 6:30 pm	Pringles plain potato chips		25 chips
1/14/17, 8:30 pm	Pediasure		8 ounces (1 bottle)
1/15/17, 8:30 am	Eggo waffle, ½ cup whole milk	1.5 cups	2 tbsp.
	Pringles plain potato chips		40 chips
	Pediasure		4 cups
1/15/17, 9:30 am	Kraft cheese stick		¼ stick
1/15/17, 11:30 am	Pediasure		16 oz, 2 (bottles)
1/15/17, 1:30 am	Skittles		30 Skittles
1/15/17, 1:30 am	Green grapes		2

Child's Three-Day Food Record

Date & Time	Food Item	Yield	Amount Consumed
