Mt. Washington Pediatric Hospital, Inc.
Feeding Day Treatment Program Family Questionnaire

___ FDT Admission (Date___________)

Child’s name: ____________________________________________
DOB: ____________________________
Caregiver name(s): _______________________________________

Part I.

1. What is your major concern about your child’s feeding? ________________________________

2. Is there evidence of pain during swallowing? _____ Yes _____ No
   If yes, explain ________________________________________________________________

3. Has your child ever had any problem with
   vomiting? _____ Yes _____ No
   choking? _____ Yes _____ No
   gagging? _____ Yes _____ No

   if yes,
   a. at what age did the problem start? __________
   b. at what age did the problem stop? __________

4. When does vomiting occur?
   during feeding? _____ Yes _____ No
   after feeding? _____ Yes _____ No
   unrelated to feeding? _____ Yes _____ No
   when upset? _____ Yes _____ No

5. How often does vomiting occur?
   _____ Times per day
   _____ Times per week
   _____ Times per month
   _____ Occasionally

6. How often does your child have a bowel movement?
   _____ Times per day
   _____ Times per week
   _____ Times per month
   _____ Occasionally

7. Are stools usually
   a. watery
   b. formed
   c. runny
   d. pasty
   e. formed

8. Has your child ever had a problem with ongoing constipation? _____ Yes _____ No
9. Does your child have any food allergies? _____Yes _____No

10. Does your child receive tube feeding? _____Yes _____No
   What is the schedule________________________________________________________
   What rate is your child’s tube-feed__________________________________________
   What formula is used for the tube feed_______________________________________
   Has there been any problems tolerating the current tube feed? _____Yes_____No
   (Describe if problems are occurring________________________________________)

PART II.

1. What kind/type of food does your child eat and how frequently does he/she eat it?

(Use the following as a guide: never = 0 times per week, seldom = 1-2 times per week, occasionally = 3-4 times per week, always = daily).

<table>
<thead>
<tr>
<th>Food Type</th>
<th>Never</th>
<th>Seldom</th>
<th>Occasionally</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fruit: oranges, bananas, peaches, etc.</td>
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<td></td>
<td></td>
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<tr>
<td>Fruit Juice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cereal</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Bread/toast</td>
<td></td>
<td></td>
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<tr>
<td>Starches/grains: muffins, donuts, pasta, crackers, pretzels, rice, etc.</td>
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<tr>
<td>Combination foods: lasagna, macaroni &amp; cheese, soup, pizza, etc.</td>
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<tr>
<td>Fats: butter, oil, mayonnaise, etc.</td>
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<tr>
<td>Sweets: cookies, candy, cake, etc.</td>
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<tr>
<td>Milk/Dairy: pudding, ice cream, yogurt, cheese, etc.</td>
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<tr>
<td>Eggs</td>
<td></td>
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<tr>
<td>Meat (red)</td>
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</tr>
<tr>
<td>Chicken</td>
<td></td>
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<tr>
<td>Pork</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Fish</td>
<td></td>
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<tr>
<td>Green veggies</td>
<td></td>
<td></td>
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<tr>
<td>Yellow veggies</td>
<td></td>
<td></td>
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</tbody>
</table>

2. What consistencies does your child eat, can eat but doesn’t, or can’t eat? What consistencies had your child never tried?
<table>
<thead>
<tr>
<th>Food Type</th>
<th>Does Eat</th>
<th>Can eat</th>
<th>Cannot eat</th>
<th>Never tried</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liquids/soups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strained baby food</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Creamy food</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(yogurt, ice cream, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Blenderized table food</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mashed table food</td>
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</tbody>
</table>

**PART III.**

1. What problem does your child have with feeding? (Check all that apply)

- [ ] Eats too fast
- [ ] Eats too little
- [ ] Messy eater
- [ ] Eats too slow
- [ ] Eats too much
- [ ] Plays with food
- [ ] Does not chew
- [ ] Pushes food away
- [ ] Leaves table
- [ ] Eats non-food items
- [ ] Does not suck
- [ ] Finicky eater
- [ ] Spits food out
- [ ] Refuses to open mouth
- [ ] Drools
- [ ] Throws/drops food
- [ ] Takes food from others
- [ ] Ruminates
- [ ] Cries or tantrums
- [ ] Refuses to swallow food
- [ ] Vomits/gags
- [ ] Turns away from spoon
- [ ] Sneaks or steals food

Other ____________________________

2. What feeding techniques do you use with your child to get him/her to eat?

- [ ] Coax
- [ ] Distract with toys
- [ ] Limit foods
- [ ] Threaten
- [ ] Change meal schedule
- [ ] Spank
- [ ] Offer reward
- [ ] Mini-meals
- [ ] Force feed
- [ ] Ignore
- [ ] Praise
- [ ] Send to room/time out
- [ ] Use television
- [ ] Change foods offered

Other ____________________________
3. Where do you feed your child?

_____ Lap
_____ Infant seat
_____ High chair  (regular ___________ adapted ___________)
_____ Booster seat
_____ Table/chair
_____ Modified chair  (e.g., wheelchair, tumbleform chair, etc)
_____ Stand/roam
_____ Floor
_____ Couch

Other

Part IV.

1. Does your child self-feed?  
   using hands?  
   using utensils?

_____ Yes  _____ No

2. Is it hard for you to tell if your child is hungry?

_____ Yes  _____ No

3. Does your child have a predictable feeding schedule?

_____ Yes  _____ No

4. Does your child’s food intake vary much from
   meal to meal?  
   day to day?

_____ Yes  _____ No

5. Is child likely to eat more at one meal than other meals?

_____ Yes  _____ No

If so, which meal and why?

6. Does your child eat better for one caregiver or the other?

_____ Yes  _____ No

If yes, please specify the individual:

7. Does your child refuse to touch certain food or objects?

_____ Yes  _____ No

8. Does your child object to certain smells?

_____ Yes  _____ No

9. How long does the feeding take?

_____ Less than 15 minutes
_____ 15-30 minutes
_____ 30-60 minutes
_____ more than 60 minutes

10. Does your child drool during feeding?

_____ Yes  _____ No
11. Can your child bite off pieces of food?  
   _____ Yes  _____ No

12. Does your child pocket food in his/her cheeks?  
   _____ Yes  _____ No

13. Does your child use any special utensils or cups?  
   _____ Yes  _____ No

14. Does your child drink from a bottle, sippy cup or cup?  
   _____ Yes  _____ No

15. Does your child eat better if he/she is sleepy during a feeding?  
   _____ Yes  _____ No

**Part V.**

1. Has your child’s hearing been evaluated?  
   _____ Yes  _____ No

   When? ________________________________  
   What were results? ________________________________

2. Is your child attentive during meals?  
   _____ Yes  _____ No

3. Is your child’s level of alertness  
   high  _____ Yes  _____ No
   moderate  _____ Yes  _____ No
   low  _____ Yes  _____ No

4. Does your child understand simple conversation?  
   _____ Yes  _____ No

5. Does your child understand commands?  
   _____ Yes  _____ No

6. How does your child communicate?  
   verbal  _____ Yes  _____ No
   non-verbal  _____ Yes  _____ No
   gestural  _____ Yes  _____ No
   electronic device  _____ Yes  _____ No

7. Does your child communicate food preferences?  
   _____ Yes  _____ No

8. Does your child sleep through the night?  
   _____ Yes  _____ No

   If not, why? _______________________________________________________________

**Thank you for taking the time to complete this questionnaire.**

**Please mail it to:**
Mt. Washington Pediatric Hospital  
Attn: Feeding Day Program  
1708 West Rogers Avenue  
Baltimore, Maryland 21209