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

____FDT Admission (Date__________)

Childs'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).

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

2. What consistencies does your child eat, can eat but doesn't, or can't eat? What consistencies had your child never tried?

Food Type	Does Eat	Can eat	Cannot eat	Never tried
Liquids/soups				
Strained baby food				
Creamy food (yogurt, ice cream, etc.)				
Blenderized table food				
Mashed table food				

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? ______ Yes ______ No
   using hands? ______ Yes ______ No
   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? ______ Yes ______ No
   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 you 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