PARENT/GUARDIAN INTERVIEW

Student: _____ Sex: _____Date of Birth: _____
Name of parents: _____Phone: _____
Address: _____
What are your main concerns about your child's mealtimes?
Describe: _____

_____

MEDICAL INFORMATION

Name of primary care physician/location: _____

Is your child seen by any of the following?

- ☐ Speech Pathologist Name and Phone #: _____
- ☐ Occupational Therapist Name and Phone #: _____
- ☐ Gastroenterologist Name and Phone #: _____
- ☐ Neurologist Name and Phone #: _____
- ☐ Pulmonologist Name and Phone #: _____

Allergies, including food allergies: _____

_____

Bowel Habits:

Frequency of Bowel Movements: _____times per (check one): ☐ Day ☐ Week

Consistency: ☐ Hard ☐ Soft ☐ Loose ☐ Watery

Medications taken on a regular basis. (please include dosage and frequency):

Medication	Dose	Prescribing Physician

Please check if your child has had the test below:

- ☐ Swallow study (MBSS/VFSS) Date: _____ Results: _____
- ☐ Upper GI (Barium Study) Date: _____ Results: _____
- ☐ Gastric emptying Date: _____ Results: _____

Does or has your child ever had GERD (gastroesphogeal reflux disorder)? If yes, please list the symptoms and treatments:

_____

_____

Has your child ever been diagnosed failure to thrive? ☐ YES/when?: _____ ☐ No

Explain how this was addressed: _____

_____

Was it resolved? _____

Was or is your child fed through feeding tube? ☐ YES ☐ NO

If yes, then when? How long? _____

What was the reason for the tube feeding?

☐ Aspiration ☐ Failure to Thrive ☐ Other:

_____

Hospitalizations (month, year, reason): _____

_____

Current Medical Problems: _____

_____

Is there any significant dental history that may affect your child's eating habits? ☐ YES ☐ NO

If yes, please explain: _____

_____

Does your child tolerate toothbrushing? ☐ YES ☐ NO

CURRENT FEEDING PRACTICES

Describe a typical family meal (i.e. does your child eat what everyone else is eating? Do you have to do anything special to his/her food? Does he/she tolerate sitting at the table?) :

_____

_____

What are your child's food preferences?

Likes	Dislikes
_____	_____
_____	_____
_____	_____

How does your child respond to new/unfamiliar foods?

_____

What kinds of food does your child eat?

☐ Regular Liquids ☐ Thickened liquids ☐ Pureed ☐ Mashed ☐ Ground

☐ Chopped ☐ Bite-sized pieces ☐ Table foods (whatever your family is eating)

Does your child feed himself/herself?

☐ YES, independently ☐ YES, with assistance ☐ NO

Does your child enjoy mealtime?

_____

How do you know when your child is hungry?

_____

_____

How do you know when your child is full?

_____

Frequency and duration of meals: _____

_____

Check all that apply:

- ☐ Choking during a meal
- ☐ Difficulty chewing
- ☐ Coughing with or without spraying of food
- ☐ Chronic respiratory problems (pneumonia) □
- ☐ Chronic ear infections
- ☐ Sensitive to being touched around the mouth
- ☐ Drooling: ___ constant ___ frequent ___ occasional
- ☐ Avoidance behaviors during feeding
- ☐ Tongue thrust
- ☐ Gurgly or "wet" voice
- ☐ Biting on utensils
- ☐ Vomiting
- ☐ Gagging
- ☐ Food refusal
- ☐ Loss of liquids when drinking
- ☐ How long does it take for your child to complete a meal: __10-20 __20-30 __ 30-40 __40-50

Does your child take any nutritional supplements?

☐ YES ☐ NO If yes, specify_____

Do certain foods/liquids appear to be more difficult for your child to eat? _____

_____

How is your child positioned during feeding?

☐ Regular chair at table ☐ Booster seat ☐ High chair

☐ Sitting in a wheelchair ☐ Tumble form chair ☐ Held on lap

☐ Adaptive chair, type: _____ ☐ Other: _____

What utensils are used?

☐ Bottle ☐ Sippy cup ☐ Cup (no lid) ☐ Straw

☐ Spoon ☐ Fork ☐ Toddler utensils

Other adaptive equipment_____

Additional Comments or Concerns: _____

_____

_____

_____ _____

PARENT SIGNATURE **DATE**

_____

PARENT'S NAME PRINTED