

PARENT/GUARDIAN INTERVIEW

Student: _____ Sex: _____ Date of Birth: _____

Name of parents: _____ Phone: _____

Address: _____

Describe your main concerns about your child's mealtimes:

CHILD'S MEDICAL INFORMATION AND HISTORY

Describe any medical diagnosis: _____

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 #: _____

Seizures: ☐ YES ☐ NO

List any 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 any feeding related tests your child has participated in:

☐ Swallow study (MBSS/VFSS) Date: _____ Results: _____

☐ Upper GI (Barium Study) Date: _____ Results: _____

☐ Gastric emptying Date: _____ Results: _____

Does or has your child ever had GERD (gastroesophageal 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: _____

Prior 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

CHILD'S 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 (check all that apply)?

- ☐ 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: _____

Positioning at home: _____ Temperature preferences: _____

Check all that apply:

- | | |
|--|--|
| ☐ Choking during a meal | ☐ Tongue thrust |
| ☐ Difficulty chewing | ☐ Gurgly or "wet" voice |
| ☐ Coughing with or without spraying of food | ☐ Biting on utensils |
| ☐ Chronic respiratory problems (pneumonia) | ☐ Vomiting |
| ☐ Chronic ear infections | ☐ Gagging |
| ☐ Sensitive to being touched around the mouth | ☐ Food refusal |
| ☐ Drooling: ___ constant ___ frequent ___ occasional | |
| ☐ Avoidance behaviors during feeding | ☐ Loss of liquids when drinking |

How long is a meal for your child: ___ 10-20 ___ 20-30 ___ 30-40 ___ 40-50

Does your child take any nutritional supplements? ☐ YES ☐ NO

If yes, specify _____

Level of appetite: _____

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