



Feeding Questionnaire

Child: _____

Date of Birth: _____

Person completing this form: _____

Does your child have any allergies? Y / N (please list allergies) _____

Do any of the following apply to your child? (please circle all that apply)

previously or currently NG fed previously or currently PEG fed uses a dummy

coughing, spluttering, gagging and/or choking with food or drink

voice or breath sound changes with food or drink

currently has or history of reflux

currently has or previously had excessive dribble

currently has or history of nasal regurgitation

currently has or history of vomiting with food or drink

recurrent chest infections or respiratory issues

When did you first become concerned about your child's feeding? _____

Are there any situations in which your child feeds better and do you do anything special to get your child to eat?

Has your child previously been seen for a feeding assessment or therapy? Y / N

If you are happy to share your child's assessment, please include it with this form.

Date of last appointment: _____ Name and role of therapist*: _____

Identified issues and recommendations: _____



Are you concerned about your child's growth? Y/N

Are you concerned about your child's nutritional intake? Y/N

What is your child's centile for Weight: _____ and Height: _____

Has your child been seen by a dietician? Y / N

Name of dietician & telephone number*: _____

Date of last appointment and recommendations: _____

Is your child taking any nutritional supplements? Y / N

Please list all supplements _____

How does your child take fluids? (please circle all that apply)

Breastfeeding Bottle Sippy cup 360 cup Open cup Straw cup

Sports bottle NGT or PEG Syringe Other _____

What is your child's fluid intake schedule & amounts? _____

Does your child avoid certain food textures, colours, etc? (please list) _____



What is your mealtime routine? Where does your child usually eat, what time does your child usually eat, who usually eats with your child, etc.

List all foods your child eats. Include brand names when relevant and list all variations (e.g. if your child eats chicken nuggets & deli chicken, please don't write "chicken," list those as two separate foods.)



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List any foods your child previously ate but now refuses _____

Is there anything else you would like to tell me? _____

On the day of the appointment:

During the mealtime observation, please offer your child the foods you normally would offer and feed your child in the usual way. Please also have available some foods your child does not eat and, if possible, a variety of textures of the foods your child does eat (e.g. puree, crunchy, soft solid, etc.) as well as some stick shaped foods such as breadsticks, carrot sticks, etc.

Please return this form prior to your initial appointment, thank you.

* NB South Lakes Speech & Language Therapy will not make contact with other professionals without your permission.