Feeding and Swallowing Clinic, 3A
1 Hospital Court
Oshawa, ON
L1G 2B9
Tel: 905-576-8711 ext. 36390
Fax: 905-721-7774

PEDIATRIC FEEDING AND SWALLOWING CLINIC

PRE-ASSESSMENT QUESTIONNAIRE

1.0 GENERAL INFORMATON:

Name: _____ **Sex: ( ) M ( ) F** **Date of Birth:** _____ dd-mm-yy

Address: _____ **City:** _____ **Postal Code:** _____

Home Phone: _____ **Health Card Number:** _____

Name of your child's family doctor and/or pediatrician: _____

Does child live with both parents? ( ) Yes ( ) No **Is your child in Day Care: ( ) Yes ( ) No**

Mother's Name: _____ **Work/Cell Phone:** _____

Father's Name: _____ **Work/Cell Phone:** _____

Guardian's Name if different than above: _____

Guardian's Address: _____ **Phone Number:** _____

2.0 ANTENATAL HISTORY:

Was the pregnancy full term? ( ) Yes ( ) No

Any complications with pregnancy and/or birth? ( ) Yes ( ) No If yes, please describe:

3.0 GENERAL HEALTH:

Does your child have any of the following?

( ) Asthma	**( ) Heart Problems**	**( ) Developmental Delay**
( ) Bronchitis	**( ) Heartburn**	**( ) Difficulty Sleeping**
( ) Pneumonia	**( ) Thyroid Problems**	**( ) Constipation**
( ) Upper Respiratory Infections	**( ) Seizure Disorder**	**( ) Diarrhea**

Is your child taking medications or vitamin/mineral supplements? ( ) Yes ( ) No If yes, please list:

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4.0 FEEDING/SWALLOWING INFORMATION

What are your specific concerns about your child's nutrition and feeding?

How does your child eat? ( ) by mouth ( ) by tube

Type of tube: _____ Date Tube Inserted: _____

Does your child have any of the following problems:

- **( ) sucking?**
- **( ) gagging?**
- **( ) vomiting and/or spitting up?**
- **( ) coughing before/during/after eating?**
- **( ) drooling?**
- **( ) persistent colic/irritability?**
- **( ) choking during meals?**
- **( ) postural changes (stiffening) during feeding?**
- **( ) difficulty sitting still?**
- **( ) crying during meals?**
- **( ) eating too little?**
- **( ) breathing difficulties during feeding?**
- **( ) gurgly voice quality before/during/after feeding?**

Does your child fuss during meals? ( ) Yes ( ) No If yes, please describe:

When did the problem(s) begin? _____

_____

Was onset of problem ( ) sudden or ( ) gradual?

Has it become ( ) better? ( ) worse? ( ) unchanged?

Has your child ever had tests or surgery for the feeding problem? ( ) Yes ( ) No If yes, please explain:

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4.0 FEEDING/SWALLOWING INFORMATION CONTINUED:

Does your child eat/drink:	Yes	No	Sometimes
• thin liquids (water, apple juice)	( )	( )	( )
• thick liquids (nectars)	( )	( )	( )
• thin purees (cereal)	( )	( )	( )
• thick purees (applesauce)	( )	( )	( )
• custards (pudding)	( )	( )	( )
• lumpy foods (scrambled eggs, junior foods)	( )	( )	( )
• soft foods (bread)	( )	( )	( )
• minced foods (ground beef)	( )	( )	( )
• hard/crunchy foods (cookies)	( )	( )	( )
• mixed consistencies (vegetable soup)	( )	( )	( )

How does your child eat?

- lying down ( )
- sitting in high chair/booster ( )
- sitting on lap ( )
- sitting in chair (at the table) ( )
- held in arms ( )
- reclined (in chair or arms) ( )
- while moving about the house ( )

Describe meal time environment (i.e. quiet, TV on, everyone sits together, etc.) _____

_____

Who prepares your child's meals? _____

Please rate the severity of the feeding/swallowing problem by circling the appropriate number.

1 2 3 4 5
Very mild Very Severe

5.0 DEVELOPMENTAL MILESTONES:

Give ages (i.e. 3 months) at which the following first occurred (approximately):

- **Held head up while on stomach _____**
- **Held head up while upright on your shoulder _____**
- **Sat alone _____**
- **Crawled in 4 point pattern _____**
- **Stood _____**
- **Walked alone _____**
- **Spoke first word _____**
- **Spoke 2 & 3 word sentences _____**
- **Toilet trained (day) _____ (night) _____**

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5.0 WEIGHT HISTORY CHART

Please fill out the following weight history chart. If your child is under age 1, please indicate a monthly weight/height. If your child is over age 1, please indicate your child's weight/height in 6 month intervals.

DATE	WEIGHT	HEIGHT

Has there been any weight loss or gain in the past 6 months? If yes, how much gain _____ or loss _____?

6.0 FEEDING HISTORY

At birth, my child was ( ) breastfed? ( ) formula fed?

If your child was breastfed, for how long? _____

If your child was formula fed, please indicate brand name. _____

Which format of formula? ( ) ready to feed ( ) liquid concentrate ( ) powder

At what age was your child weaned off breastmilk/formula? _____

If your child is still on breastmilk/formula, please indicate the amount your child has at each feed.

_____

_____

At what age were solids introduced? _____

What foods were introduced first? _____

At what age were textured foods introduced? _____

At what age did your child start drinking from a cup? _____

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7.0 DIET

What does your child's diet consist of? Please list the specific foods within each food group.

Milk and Milk Products
Vegetables and Fruits
Meat and Alternatives
Grain Products

Does your child avoid any foods or drinks? If so, please list. Also, how often have these foods been introduced?

What utensils do you use to feed your child?

- **( ) Bottle and nipple**
- **( ) Cup**
- **( ) Straw**
- **( ) Spoon**
- **( ) Fingers**
- **( ) Child is self feeding (by either spoon or fingers)**

Does your child suffer from food allergies or food sensitivities? ( ) Yes ( ) No If yes, please explain:

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8.0 TOUCH, PERCEPTION, COORDINATION AND BEHAVIOURAL INFORMATION

The following is a list of symptoms that may indicate deficits in sensory integration. Please indicate how frequently the following behaviours occur by *circling* the appropriate number in the left column:

N = Not Applicable 1 = Never 2 = Occasionally 3 = Frequently 4 = Consistently

Does your child:

N 1 2 3 4	Avoid touch or contact?	N 1 2 3 4	Have a short attention span?
N 1 2 3 4	Dislike having hair or face washed?	N 1 2 3 4	Become frustrated easily?
N 1 2 3 4	Dislike being in crowds?	N 1 2 3 4	Crave attention?
N 1 2 3 4	Appear not to feel pain as much as other children?	N 1 2 3 4	Have difficulty falling asleep at night?
N 1 2 3 4	Over-react when touched unexpectedly?	N 1 2 3 4	Seem to "tune-out" at times?
N 1 2 3 4	Become distracted when eating with or near others?	N 1 2 3 4	Take physically aggressive action against others?
N 1 2 3 4	Does your child ignore or dislike offensive/strong odours?	N 1 2 3 4	Prefer to play alone?
N 1 2 3 4	Act as though all food tastes the same?	N 1 2 3 4	Have poor eye contact?
N 1 2 3 4	Manipulate small objects with difficulty?	N 1 2 3 4	Accept change poorly?
N 1 2 3 4	Have an excessive need to touch things?	N 1 2 3 4	Have trouble refocusing attention if interrupted?
N 1 2 3 4	Dislike baths or showers?	N 1 2 3 4	Insist on everything being in a certain place?
N 1 2 3 4	Appear to be irritated by cloth of certain textures?	N 1 2 3 4	Have difficulty sitting still? (restless)
N 1 2 3 4	Prefer long-sleeved garments even in warm weather?	N 1 2 3 4	Dislike having food on hands or face?
N 1 2 3 4	Crave hugging or rough play?		
N 1 2 3 4	Become irritated when someone is close to him/her?		
N 1 2 3 4	Put objects in mouth?		
N 1 2 3 4	Grasp age-appropriate utensils?		
N 1 2 3 4	Move tongue or mouth when working with hands?		

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9.0 COMMUNITY SERVICES

Is your child currently involved in any of the following community agencies/services?

COMMUNITY AGENCY	NO	YES	CONTACT PERSON
Grandview Children's Centre			
Infant Development			
Resources for Exceptional Children			
Behaviour Management			
Other:			

10.0 EXPECTATIONS:

What are your expectations of the Feeding Clinic's assessment?

_____
Name of Person Completing Questionnaire

_____
Relationship to Client

_____
Date

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11.0 DAILY FOOD DIARY

The food diary will help the Dietitian give you advice about your child's diet. The food diary will be analyzed for energy, protein and various vitamins and minerals. Please make the food record as accurate as possible.

What to do:

- **Complete a food diary for 3 days.**
- **Every time your child has something to eat or drink, write it down.**
- **Consider the cooking method used to prepare the food. Make a note of sauces, condiments or butter/margarine used.**
- **When a mixed food is eaten (sandwich, soup or stew), write down the ingredients used.**
- **Please record all meals, snacks, drinks, desserts and the place where the meal is eaten.**
- **Describe your child's mood during mealtime/snack (i.e. happy, agitated, crying, turning face away from food, pushing food away, can't sit still, etc.)**

See sample next page.

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SAMPLE

BREAKFAST - Description of Food/Drink **TIME:** 7:30 a.m. **PLACE:** Home/kitchen table	**AMOUNT TAKEN** **MOOD:** Happy
Orange juice Rice Krispies 2% milk for cereal Brown sugar banana	½ cup 1 cup ½ cup 1 tsp 1/2
MID-MORNING SNACK – Description of Food/Drink **TIME:** 10:00 a.m. **PLACE:** Day Care	**AMOUNT TAKEN** **MOOD: Happy**
Arrowroot cookies grapes Water	2 ½ cup ½ cup
LUNCH – Description of Food/Drink **TIME:** 12:00 p.m. **PLACE:** Home/Kitchen table	**AMOUNT TAKEN** **MOOD:** Unsettled/tired
Tuna sandwich (2 slices whole wheat brad, 3 tbsp tuna packed in water, 1 tsp butter, 1 tbsp mayo) 2% milk Apple slices Carrot sticks	½ sandwich 1 cup 1 small 2
MID-AFTERNOON SNACK – Description of Food/Drink **TIME:** 3:00 p.m. **PLACE:** In front of t.v	**AMOUNT TAKEN** **MOOD:** Settled
Soda crackers Cheddar cheese 2% milk	3 1 oz ½ cup
SUPPER – Description of Food/Drink **TIME:** 6:00 p.m. **PLACE:** Restaurant	**AMOUNT TAKEN** **MOOD:** Playful
Broiled chicken breast White rice Corn Green beans 2% milk Vanilla Ice-cream	½ breast ½ cup ¼ cup ¼ cup 1 cup ½ cup
MID-EVENING SNACK – Description of Food/Drink **TIME:** 7:30 p.m. **PLACE:** Home/Kitchen table	**AMOUNT TAKEN** **MOOD:** Crying
Blueberry muffin Raspberry/blueberry mix Water	½ ¼ cup ½ cup

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DAY 1

FOOD DIARY FOR: _____

BREAKFAST - Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
MID-MORNING SNACK – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
LUNCH – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
MID-AFTERNOON SNACK – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
SUPPER – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
MID-EVENING SNACK – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**

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DAY 2

FOOD DIARY FOR: _____

BREAKFAST - Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
MID-MORNING SNACK – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
LUNCH – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
MID-AFTERNOON SNACK – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
SUPPER – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
MID-EVENING SNACK – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**

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DAY 3

FOOD DIARY FOR: _____

BREAKFAST - Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
MID-MORNING SNACK – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
LUNCH – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
MID-AFTERNOON SNACK – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
SUPPER – Description of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**
MID-EVENING SNACK – Description Of Food/Drink **TIME:** **PLACE:**	**AMOUNT TAKEN** **MOOD:**

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Notes: _____