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:

Medication:

Dose:

Prescribing Physician:

Medication:

Dose:

Prescribing Physician:

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  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 does it take for your child to complete a meal:**

10-20 minutes

20-30 minutes

30-40 minutes

40-50 minutes

**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

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PARENT’S NAME PRINTED