

Child's Name _____	Date _____
Child's Date of Birth _____	Age _____ yrs. _____ mo.
Address _____	
Mother's Name _____	Siblings / Ages _____
Father's Name _____	_____
Pediatrician _____	Other Siblings with feeding problems _____
Referring Physician _____	_____
Other Physicians _____	_____

1. How does your child feed, by mouth, G-tube, N-G tube? Is / was your child breastfed?
2. Has your child ever fed by a G-tube? N-G tube? When? Why? How long?
3. What, if any, are your child's medical issues?
4. Does your child have a history of hospitalizations, pneumonia, aspiration or reflux?
5. What is your child's evacuation schedule? Regular or constipated for stools / voids?
6. What foods or formula does your child eat and enjoy? What is your child's feeding schedule?
7. How are solids prepared? (e.g. blenderized, pureed, cut table foods, etc.)
8. What foods won't your child eat?
9. Does your child have any allergies to foods, drugs, other agents?
10. How much food does your child consume during each meal?
11. Can your child feed himself / herself? Special modifications?
12. How long is a usual mealtime?

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Feeding/Oral Motor Intake Caregiver Questionnaire**



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- 13. How is your child helped or positioned for feeding? Specialized seating? Extra supports (towel rolls, cushions, etc.)?**
- 14. Does your child ever choke on food or liquid?**
- 15. Has your child ever had a swallowing study? When? Where? Results?**
- 16. Has other testing been completed (e.g. Milkscan, PH probe, etc.)?**
- 17. What feeding techniques or special equipment are presently being used?**
- 18. What is the name of the school your child attends?**
- 19. Are services provided for your child? (OT, Speech, PT) Name & number?**
- 20. Who is involved in your child's feeding (at home, school, daycare)?**
- 21. What are your greatest concerns regarding your child's feeding?**
- 22. Does your child have difficulties with speech production?**
- 23. What are your greatest concerns regarding your child's Speech development?**
- 24. Has a Speech evaluation been completed? When? Where? By whom?**
- 25. Is your child taking any medications, special oils, aspirin, etc to assist with a physical need?**

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26. Does your child use a oral prostheses / palate obturator for feeding?

27. What other concerns do you have regarding feeding, oral motor functions, speed production?

During the feeding evaluation, I would like to make the setting as much as possible like your child's usual mealtime environment. Please have any special equipment including dishes, utensils, cups, straws, bottles, etc.

You may bring a sampling of foods your child likes and will eat, as well as a sampling of food that are more difficult or refused. We will want foods eaten with a spoon i.e. applesauce, pudding, etc., as well as more textured, chewable finger foods i.e. crackers, cookies, sandwich. Please have 1-2 liquids available, including water.

Person Completing Questionnaire _____
Relationship to child _____
Signature _____

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Structure

Tone: _____

Strength: _____

Sensory Issues

Sensitivity: _____

Drooling: _____

Reflexes

Lingual Gag: _____

Coughing: _____

Rooting: _____

Movement / Function

Facial Symmetry: _____

Lips / Cheeks: _____
Resting Posture: _____
Buccal Fat Pads: _____
Closure / Strength: _____

Tongue: _____
Mobility: _____
Protrusion: _____
Lateralization: _____
Retraction: _____

Jaw: _____
Stability: _____
Mobility: _____
Repetitive Cycles: _____

Sucking: _____
Bottle: _____
Breast: _____
Straw: _____
Cup drinking: _____
Sippy cup: _____

Biting & Chewing: _____

Food Textures: _____

Swallowing: _____

Respiration: _____

Communication: _____

History of Tests

MBS	When	Where
PH Probe	When	Where
Bronchoscopy	When	Where

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SUMMARY

Major Difficulties: _____

Strengths: _____

Therapy Activities: _____

Long Term Goals: _____

Short Term Goals: _____

Short Term Objectives: _____

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