Parent Interview
For Feeding/Swallowing Concerns

Student: _____ Date: _____

Diagnosis: _____ Date of Birth: _____ Present Height: _____

Present Weight: _____

A. Family and Birth History: (Please check and comment on any areas that apply)

Birth Weight _____ Premature (How many weeks?) _____ Full Term

Complications at birth _____

Primary caregivers: _____ Parent _____ Babysitter _____ Foster Parent _____ Other

Cleft palate or other structural differences in the mouth/face area? _____

Respiratory concerns _____

Allergies (food, environmental) _____

Pneumonia _____

Heart Problems _____

Other (family history etc.) _____

Medications _____

Vision

Impairment/concerns _____

Hearing Loss/concerns _____

B. Feed History

Tube Feeding _____ Type of tube feeding:

Date started _____ Date ended _____

AM _____ PM _____ Continual _____

Early sucking problems

Onset of feeding problems (how & when)

_____

Change in feeding problems over time

_____

_____

Student Name: _____

_____ Reflux or other GI problems _____

_____ Video Fluoroscopy/swallow studies _____

_____ Prior feeding management/intervention _____

_____ Bowel movements _____

_____ Other concerns you can describe for us?

_____
_____
_____
_____
_____
_____

C. Current status:
1) Child's diet: what does your child usually eat for:

Breakfast

Lunch

Dinner

Snacks

2) How is the food prepared (Please check all that apply)

a. _____ Regular liquid
b. _____ Thick liquid
c. _____ Commercial strained baby food
d. _____ Food prepared in the blender
e. _____ Ground or commercial junior food
f. _____ Mashed soft table foods
g. _____ Regular table food
h. _____ Other: _____
_____

3) Which of these types of foods are easiest for your child?

4) Which of these types of food are hardest for your child?

Student Name: _____

5) What "utensils" do you usually use when feeding your child? (check all that apply)

_____ Bottle _____ Cup _____ Straw _____ Spoon _____ Fork

_____ Fingers _____ Other _____

6) Does your child have favorite food tastes? What are they?

7) Does your child have favorite food textures? What are they?
- Crisp foods, e.g. cereals, raw vegetables, toast, pretzels
- Slippery foods, e.g. eggs
- Sipping and chewing, e.g. soups with vegetables, etc.
- Large bites and chewing, e.g. apples

8) Does your child prefer food at a certain temperature (cold, warm, hot, room temp?)

9) Does your child drool/gag when eating?

10) Does your child bite/chew?

11) Does your child use his/her tongue?

12) Who usually feeds your child?

13) Who else can feed your child?

14) Where is your child fed? (In a chair On your lap?) and what is the environment (noisy, quiet, stressed, calm?)

15) How long does it take to feed your child, or can your child eat independently? Please Describe: _____

16) What is the average amount of food and liquid your child takes during that time?

17) Are there any interfering motions of his/her head, hands or feet? Describe

18) When was your child's last dental checkup??

- Describe typical mealtime. How do you react when your child refuses to eat?