

## Parent Nutrition/Feeding Questionnaire (for Ages 0-5 years)

Child's Name: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Dr. Name: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date: \_\_\_\_\_ Parent email: \_\_\_\_\_

Is your child currently followed by a WIC clinic?  YES  NO

Has your child now or ever been seen by a dietitian or nutritionist?  YES  NO If yes, by whom? \_\_\_\_\_

**DIRECTIONS: Please circle your answers. For every YES answer, add the number in the last column. Put the total score at the bottom. For Scores 4 or greater, send copy to AEA Occupational Therapist. Parent sign release and send copy to CHSC RD.**

1 Does your child have a health problem (do <b>not</b> include colds or flu)? If yes, what is it?	YES	NO	1
2 Is your child: Small for age? <input type="checkbox"/> Too thin? <input type="checkbox"/> Too heavy? <input type="checkbox"/> (If you check any of the above, please circle YES)	YES	NO	3
3 Does your child have feeding problems? If yes, what are they?	YES	NO	3
4 Is your child's appetite a problem? If yes, describe:	YES	NO	1
5 Is your child on a special diet? If yes, what type of diet?	YES	NO	2
6 Does your child take medicine for a health problem? (Do <b>not</b> include vitamins, iron or fluoride) Name of medicine(s):	YES	NO	1
7 Does your child have food allergies? If yes, to what foods?	YES	NO	1
8 Does your child use a feeding tube or other special feeding method? If yes, explain:	YES	NO	4
9 Does your child have trouble eating any of these foods (Check all that apply) Milk <input type="checkbox"/> Meats <input type="checkbox"/> Vegetables <input type="checkbox"/> Fruits <input type="checkbox"/>	YES	NO	1
10 Does your child have any of these problems? (Check all that apply) Sucking <input type="checkbox"/> Swallowing <input type="checkbox"/> Chewing <input type="checkbox"/> Gagging <input type="checkbox"/> Meals lasting longer than 30 minutes <input type="checkbox"/>	YES	NO	3
11 Does your child have any of these problems? (Check all that apply) Loose Stools <input type="checkbox"/> Hard Stools <input type="checkbox"/> Throwing up <input type="checkbox"/> Spitting Up <input type="checkbox"/>	YES	NO	3
12 Does your child eat clay, paint chips, dirt or any other things that are not food? If yes, what?	YES	NO	2
13 Does your child refuse to eat, throw food, or do other things that upset you at mealtime? If yes, explain:	YES	NO	2
14 For infants <b>under 12 months</b> who are bottle fed: Does your child drink less than 3 (8-ounce) bottles of formula or milk per day?	YES	NO	1
15 For children <b>over 12 months</b> : (Check if applies and circle the YES) Is your child <b>not</b> using a cup? <input type="checkbox"/> Is your child <b>not</b> finger feeding? <input type="checkbox"/>	YES	NO	1
16 For children <b>over 18 months</b> : Does your child still take most liquids from a bottle?	YES	NO	2
17 For children <b>over 18 months</b> : Circle YES if your child is <b>not</b> using a spoon	YES	NO	2

Other comments: \_\_\_\_\_

**TOTAL:** \_\_\_\_\_

Scored by: \_\_\_\_\_ Date: \_\_\_\_\_ Agency and phone: \_\_\_\_\_