

# J.Z. MANN PEDIATRIC THERAPY



JANELLE Z. MANN, PT, PCS, C/NDT  
*Pediatric Certified Specialist*

Phone: (910) 347-2212

Fax: (910) 347-6003

410 New Bridge St., Suite 10A  
Jacksonville, NC 28540

[www.jzmannpediatrictherapy.com](http://www.jzmannpediatrictherapy.com)  
[therapist@jzmannpediatrictherapy.com](mailto:therapist@jzmannpediatrictherapy.com)

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

## FEEDING QUESTIONNAIRE FOR OCCUPATIONAL THERAPY EVALUATIONS

Please list accepted foods your child currently eats in the appropriate categories below. Please include if your child only accepts/eats specific brands, canned vs. fresh, or if it must be prepared a certain way. Thank you!

### Baby or table foods your child will eat:

Stage of baby food your infant/child will eat:    \_\_\_ 1    \_\_\_ 2    \_\_\_ 3

Fruits

Vegetables

Meats/Proteins (beans, nuts, etc.)

Starches (Breads, pasta, rice etc.)

Dairy (cheese, yogurt, milk, etc.)

Miscellaneous/Snack Foods

Condiments (i.e., catsup, mustard, etc)

Please list current fluids your child accepts (formula, water, juice, milk) and how much he/she typically drinks in a day (including oz. of bottle/sippy cup).

Please list foods your child has eaten in the past but currently does not like/eat:

**Form continued on back**

Parents/Guardians:

J.Z. Mann, Pediatric Therapy will be evaluating how your child eats and drinks. Please help with the following:

On the day of the evaluation, we would like to observe a typical feeding.

1. Bring your child somewhat hungry so that he/she will eat during the evaluation.
2. Bring items your child typically uses at meals and small amounts of food to include:
  - Spoons/utensils your child uses.
  - Cups and sippy cups and/or bottles with a variety of nipples that you have used to feed your baby.
  - Foods that your child enjoys eating.
  - Foods that are difficult for your child to eat.

If you have any questions please list below or feel free to call 910-347-2212. Thank you! We look forward to meeting you and your child!

---

---

---

---

---

---

---

---

I wish for my child to be evaluated and/or treated by J.Z. Mann, Pediatric Therapy.

Parents are expected to provide food for their child during feeding therapy; however, on some occasions J.Z. Mann Pediatric Therapy may provide it. I hereby release J.Z. Mann, Pediatric Therapy from any liability regarding known/unknown food allergies/sensitivities that my child may have.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Date