CHILD'S NAME:_____ **DATE OF BIRTH**: _____

OCCUPATIONAL THERAPY (OT) QUESTIONS

Does child:

have problems with fine motor tasks (i.e. □ dressing; □ buttons, □ zippers, □ grasping utensils/pencils, etc.)? □ **Y** □ **N**

have any sensory issues (i.e. □ problems with clothing tags, □ textures, □ bathing, □ tooth brushing, □ hair brushing, □ tantrums in stores or if "routine is not followed", etc.)? □ **Y** □ **N**

seek deep pressure (□ throws self on ground/furniture, □ likes bear hugs, □ rough play, etc.)? □ **Y** □ **N**

have handwriting issues □ **Y** □ **N**

have feeding issues such as choke/gags of foods, will not eat "age-appropriate" foods, doesn't like certain textures of food such as "soft/mushy" etc? □ **Y** □ **N** *If yes, please fill out Feeding Questionnaire on page 2.*

Feeding/Nutrition

Has child had food allergy testing? □ **Y** □ **N**

Does child have any food allergies/sensitivities (i.e. lactose intolerance)? □ **Y** □ **N** *If yes, to what & what is reaction?*

Does child spit up more often/ more fluid than normal □ **Y** □ **N** *If yes, explain:*

Does child cough a lot? □ **Y** □ **N** *If yes, explain:*

Does child often sound congested? □ **Y** □ **N** *If yes, explain:*

Does child have reflux? □ **Y** □ **N** *If yes, is child medicated for reflux?* □ **Y** □ **N**

Does child: *(check all that apply)*

□ eat table food	□ finger food
□ drink from bottle without leakage	□ drink from sippy cup
□ drink from uncovered cup	□ choke or gag when feeding
□ currently require tube feeding (NG, G, NJ)	□ use utensils

Has the child required tube feeding in the past? □ **Y** □ **N**

Family Concerns/Goals:

Please your OT concerns: _____

_____

_____

Please list your OT goals for the child for the next SIX months: _____

_____

_____

_____

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FEEDING QUESTIONNAIRE:

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

Dairy

Vegetables

Miscellaneous/Snack Foods

Meats/Proteins (beans, nuts, etc.)

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

Starches (breads, pasta, rice, etc.)

Please list current fluids your child accepts (formula, water, juice, milk) & 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:

J.Z. Mann Pediatric Therapy will be evaluating how your child eats & 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 & small amounts of food to include:
    - Spoons/utensils your child uses;
    - Cups & sippy cups &/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.

I wish for my child to be evaluated 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 _____

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