GIG CYMRU NHS WALES | Bwrdd Iechyd Aneurin Bevan Health Board

Speech and Language Therapy

SLT 0005

PARENT/CARER FEEDING QUESTIONNAIRE

Please complete this form and bring it to your first appointment

1 PERSONAL INFORMATION

Child's name:		Date of birth:	
Name of person completing this form:			
Relationship to child:			
What languages are spoken at home?			
Who lives at home? (include the ages of any other children:			
Paediatrician			
G. P. and Surgery:			
Health Visitor:			
Other professionals involved			
Playgroup/Nursery or school attended:			

2 BACKGROUND INFORMATION

Were there any difficulties.complications with the:	
Pregnancy:	
Birth:	

Is your child on any medication?	Yes ☐	No ☐
If yes, please list/give details:		
Does your child have any allergies?	Yes ☐	No ☐
If yes, please list/give details:		
Does your child have a medical diagnosis?	Yes ☐	No ☐
If yes, please specify:		

Does your child suffer with (Please tick):							
Frequent colds	☐	Chest infections	☐	Asthma	☐	Breathing problems	☐
Dribbling	☐	Choking	☐	Gagging	☐	Gurgly voice	☐
Constipation	☐	Vomiting	☐	Epilepsy	☐	Ear infections	☐
Sight problems	☐	Dental Problems	☐	Snoring	☐	Hearing problems	☐

Does your child have a dummy?	Yes ☐	No ☐

Can your child?							
Hold their head up	☐	Babble	☐	Sit	☐	Walk	☐

Use some words		Crawl		Stand	

Does your child require any additional support, e.g. specialist chairs	Yes		No	

If yes, please specify:

3 EATING AND DRINKING SKILLS

Has your child been tube fed?	Yes		No	

If Yes	
When?	
How Long:	

Does your child eat the following textures:					
Normal foods		Soft/mashed foods		Pureed foods	

List the foods your child enjoys:

What food does your child find:		
Easy		Difficult

Does your child drink the following consistencies?					
Normal liquid		Thick liquids		Very thick liquids	

Does your child prefer foods at a certain temperature?	Yes		No	

If Yes:	Cold		Warm		Hot		Room temperature	

Has your child's ability to eat or drink changed recently?	Yes		No	

If yes, please explain:

4 MEAL TIMES

How long do meal times take?	
How much do they eat?	

Does your child use the following utensils at meal times?										
Breast		Spoon		Fingers		Fork		Knife		
Bottle		Cup		Beaker		Straw		Specialist Equipment		

How much adult help does your child need when **eating**?				
They are independent		Some support		Full adult help	

How much adult help does your child need when **drinking**?				
They are independent		Some support		Full adult help	

Where does your child get fed? (e.g., high chair/lap)	

Does your child mind having food on their hands?	Yes		No	

Does your child mind having their teeth brushed?	Yes		No	

We ask you for information about your child so that they may received proper care and treatment. Personal information will only be used for legally registered purposes and only be available to authorised receipients.

WEBSITE ADDRESS: www.sltgwentabhb.wales.nhs.uk