

# Carolina Pediatric Dysphagia

*Pediatric Dysphagia and Oral Myofunctional Disorders*

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## Oral Sensori-motor Evaluation Questionnaire

(Please answer all questions that apply to your child.)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Pediatric Group: \_\_\_\_\_

What diagnosis does your child have? \_\_\_\_\_

Chief Feeding Concerns \_\_\_\_\_

What are your goals for this evaluation? \_\_\_\_\_

Has your child received previous services for this problem? \_\_\_\_\_ Where: \_\_\_\_\_

### **Prenatal/Birth History:**

Was your child born full term? Yes \_\_\_ No \_\_\_ If no, how many weeks gestation? \_\_\_\_\_

Birth Weight and Percentile \_\_\_\_\_ Birth Height and Percentile \_\_\_\_\_ Apgar Scores \_\_\_\_\_

Was your child in the NICU? Yes \_\_\_ No \_\_\_ If yes, why and for how long? \_\_\_\_\_

Did your child pass the newborn hearing screening? \_\_\_ List any hearing concerns? \_\_\_\_\_

Circle all that apply to your child prior to discharge: Intubation / Oxygen / OG tube feeds / NG-tube feeds /

Surgery (please describe) \_\_\_\_\_

Other \_\_\_\_\_

### **Developmental/Sensory Processing History:**

Does your child attend day care or school? \_\_\_\_\_

When did your child sit unassisted? \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Said 1st word? \_\_\_\_\_

What is your child's main form of communication? Words \_\_\_ Gestures \_\_\_ Signs \_\_\_ Body Language \_\_\_

What is your child's current weight? \_\_\_\_\_ Weight Percentile \_\_\_\_\_ Height Percentile \_\_\_\_\_

Is weight gain a concern? Yes \_\_\_ No \_\_\_ Is your child currently receiving any other therapies? \_\_\_\_\_

If yes, please list: \_\_\_\_\_

Does your child have a visual impairment? Yes \_\_\_ No \_\_\_ Auditory impairment? Yes \_\_\_ No \_\_\_

Where tested? \_\_\_\_\_

Does your child sleep through the night? Yes \_\_\_ No \_\_\_ Is s/he able to maintain eye contact? Yes \_\_\_ No \_\_\_

Does/Did your child hold her/his bottle? Yes \_\_\_ No \_\_\_ Does your child feed her/himself? Yes \_\_\_ No \_\_\_

Does your child like to swing? Yes\_\_\_ No\_\_\_ Does your child seek rough play? Yes\_\_\_ No\_\_\_

Does your child enjoy playing in a sandbox? Yes\_\_\_ No\_\_\_

Is your child sensitive to certain fabric make? Yes\_\_\_ No\_\_\_

Will your child tolerate being messy or having their hands messy? Yes\_\_\_ No\_\_\_

**General Medical History:**

Has your child ever been hospitalized? \_\_\_\_\_ If yes, why? \_\_\_\_\_

**Circle** all procedures your child has had and **fill in the approximate dates:** EKG \_\_\_\_\_ EEG \_\_\_\_\_

MRI \_\_\_\_\_ Other \_\_\_\_\_

Please list any medications your child is currently taking and the dosage per day: \_\_\_\_\_

**Bronchopulmonary and Otorhinolaryngeal History:**

Is your child congested? Never \_\_\_ Sometimes \_\_\_ Always \_\_\_ When eating \_\_\_ When drinking \_\_\_

Has your child had any of the following (please circle all that apply): Colds / Upper respiratory infections /

Bronchitis / Ear infections / Pneumonia / Thrush / Bad diaper rash

How many times has your child been treated with antibiotics? \_\_\_\_\_ Were they effective? Yes\_\_\_ No\_\_\_

Has your child had any problems with his/her tonsils or adenoids? \_\_\_ Family history? \_\_\_

Please explain: \_\_\_\_\_

Does your child do any of the following? (check all that apply) Snore \_\_\_ Audibly Breathe At Rest \_\_\_ Drool \_\_\_

Audibly Breathe During Activity \_\_\_ Audibly Breathe While Sleeping \_\_\_ Have an open mouth posture \_\_\_

**Gastrointestinal History:**

Has your child been diagnosed with gastroesophageal reflux? Yes\_\_\_ No\_\_\_

If yes, please list any reflux medications your child is currently taking and the dosage per day: \_\_\_\_\_

Has your child ever completed any of these procedures? (include when and where)

Upper GI (Barium Swallow) \_\_\_\_\_ Endoscopy \_\_\_\_\_

Gastric emptying scan \_\_\_\_\_ pH Probe \_\_\_\_\_

Does anyone in your family have a history of gastroesophageal reflux or other GI issues? Yes\_\_\_ No\_\_\_

If yes, please list relationship to child and issue: \_\_\_\_\_

**As an infant** did your child spit up/vomit? Yes\_\_\_ No\_\_\_ Did it come out his/her nose? Yes\_\_\_ No\_\_\_

Did you feel like your child spit up more than most? Yes\_\_\_ No\_\_\_

How many times per day did your child typically spit up/vomit? \_\_\_ Times per week? \_\_\_

When did s/he usually spit up/vomit? \_\_\_\_\_

Could you predict when it would happen? Yes\_\_\_ No\_\_\_ If yes, how did you know? \_\_\_\_\_

Could you identify food in vomit? Yes\_\_\_ No\_\_\_ Has reflux gotten better with time? \_\_\_\_\_

**As an infant**, did your child had any of the following physical and/or behavioral symptoms (please check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> crying/fussing during or after feeds | <input type="checkbox"/> seeming desire to eat and then refused                                       |
| <input type="checkbox"/> reduced appetite/limited intake      | <input type="checkbox"/> eating small but frequent meals  |
| <input type="checkbox"/> grazing throughout the day           | <input type="checkbox"/> requiring distractions in order to eat                                       |
| <input type="checkbox"/> limiting textures                    | <input type="checkbox"/> not progressing to age-appropriate foods                                     |
| <input type="checkbox"/> gagging/retching/coughing            | <input type="checkbox"/> arching <input type="checkbox"/> repeat swallows not associated with feeding |

**Currently**, does your child spit up/vomit? Yes\_\_\_ No\_\_\_ Does it come out of his/her nose? Yes\_\_\_ No\_\_\_

How many times per day does your child typically spit up/vomit?\_\_\_\_\_ How many times per week? \_\_\_\_\_

When does s/he usually spit up/vomit? \_\_\_\_\_ Can you predict when it will happen? Yes\_\_\_ No\_\_\_

If yes, how do you know? \_\_\_\_\_ Can you identify food in the vomit? Yes\_\_\_ No\_\_\_

**Currently**, does your child had any of the following physical and/or behavioral symptoms (please check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> crying/fussing during or after feeds                             | <input type="checkbox"/> seeming desire to eat and then refuses      |
| <input type="checkbox"/> reduced appetite/limited intake                                  | <input type="checkbox"/> eating small but frequent meals             |
| <input type="checkbox"/> grazing throughout the day                                       | <input type="checkbox"/> requiring distractions in order to eat      |
| <input type="checkbox"/> limiting textures  | <input type="checkbox"/> not progressing to age-appropriate foods    |
| <input type="checkbox"/> gagging/retching/coughing  | <input type="checkbox"/> arching                                     |
| <input type="checkbox"/> hiccupping/burping   | <input type="checkbox"/> repeat swallows not associated with feeding |
| <input type="checkbox"/> preference for crunchy foods and/or strong spicy or sour flavors |  |

Do you feel like your child's bowel movements are normal? Yes\_\_\_ No\_\_\_

Does your child suffer from (please circle) Constipation? Diarrhea? Stomachache?

How many bowel movements does your child have per day? \_\_\_\_\_ Is the bm? (please circle) Hard / Runny / Soft

Do you stimulate a bowel movement with circle diet? Medication? Suppositories? Thermometer?

Describe any past or present issues with constipation or diarrhea: \_\_\_\_\_

Have you ever identified food in a bowel movement? Yes\_\_\_ No\_\_\_ Does your child take probiotics? \_\_\_\_\_

**Allergies and Food Intolerances:**

Does your child have a diagnosis of food or environmental allergies? Yes\_\_\_ No\_\_\_

Has your child ever had allergy testing? Yes\_\_\_ No\_\_\_ If yes, type of test and results: \_\_\_\_\_

If no, do you suspect any allergies? Yes\_\_\_ No\_\_\_ If yes, please list: \_\_\_\_\_

Has your child had eczema? Yes\_\_\_ No\_\_\_ Other rashes? Yes\_\_\_ No\_\_\_ Yeast infections? Yes\_\_\_ No\_\_\_

Does anyone in your family have allergies or food intolerances? Yes \_\_\_ No \_\_\_ If yes, please list relationship to child and what they are allergic to: \_\_\_\_\_

**Feeding History:**

How is your child currently fed? Breast \_\_\_ Bottle \_\_\_ NG Tube \_\_\_ G-Tube \_\_\_ Puree \_\_\_ Solids \_\_\_  
Other \_\_\_\_\_

Was your child breast-fed? Yes \_\_\_ No \_\_\_ If yes, for how long? \_\_\_\_\_

If breast-feeding was discontinued, please check why: Difficulty latching on \_\_\_\_\_ Personal preference \_\_\_\_\_

Weight gain issues (baby) \_\_\_\_\_ Return to work \_\_\_\_\_ Anatomical anomaly \_\_\_\_\_ Other \_\_\_\_\_

Is/was your child on formula? Yes \_\_\_ No \_\_\_ Current formula \_\_\_\_\_

Have you switched formulas? Yes \_\_\_ No \_\_\_ List all formulas tried and why they were changed: \_\_\_\_\_

What is the name of the nipple/bottle you are using/used? \_\_\_\_\_

Have you switched bottle nipples? Yes \_\_\_ No \_\_\_ If yes, names and why? \_\_\_\_\_

Does your child currently drink from a bottle? \_\_\_ Sippy cup \_\_\_ Cup with straw \_\_\_ Open cup \_\_\_

Does your child choke? \_\_\_ Cough \_\_\_ Gag \_\_\_ Vomit during feeding? \_\_\_ Please describe: \_\_\_\_\_

Does your child indicate hunger? Yes \_\_\_ No \_\_\_ Does your child like to eat? Yes \_\_\_ No \_\_\_

Has your child ever completed a Modified Barium Swallow Study? Yes \_\_\_ No \_\_\_

Where/When? \_\_\_\_\_

	Child's Age	Was it Easy? (Y/N)	If no, please describe	Has it gotten easier?
Spoon-feeding first introduced				
Chunky Stage 3 foods introduced				
Finger foods first introduced (i.e., Cheerios, biter biscuits, etc.)				
Table foods first introduced				

What makes you stressed about your child's feeding? \_\_\_\_\_

Have you ever forced your child to eat? Yes \_\_\_ No \_\_\_ Has forcing ever resulted in refusal to eat? Yes \_\_\_ No \_\_\_

Has forcing ever resulted in vomiting? Yes \_\_\_ No \_\_\_ Have you ever bribed your child to eat? Yes \_\_\_ No \_\_\_

Has it worked? Describe: \_\_\_\_\_

Where does your child eat best? \_\_\_\_\_ When does your child eat best? \_\_\_\_\_  
Do you have a meal when your child is eating? Yes \_\_\_ No \_\_\_ Does your child sit during mealtime? Yes \_\_\_ No \_\_\_  
Do you need to distract your child so he/she will eat? Yes \_\_\_ No \_\_\_ Explain: \_\_\_\_\_  
Does your child takes in adequate nutrition from food? Yes \_\_\_ No \_\_\_ from formula/liquid? Yes \_\_\_ No \_\_\_  
How many ounces of liquid does your child take a day? Formula \_\_\_\_\_ Milk \_\_\_\_\_ Water \_\_\_\_\_ Juice \_\_\_\_\_  
Do you and your significant other(s) agree on your child's difficulty with feeding and ways to manage mealtime behaviors? \_\_\_\_\_

**Oral Motor History:**

How many teeth does your child have? \_\_\_\_\_ Is tooth brushing stressful? Yes \_\_\_ No \_\_\_  
Do you need to force tooth brushing Yes \_\_\_ No \_\_\_ Did your child mouth objects as an infant? Yes \_\_\_ No \_\_\_  
Does your child mouth objects now? Yes \_\_\_ No \_\_\_ Does your child take a pacifier? Yes \_\_\_ No \_\_\_  
If no, did she/he? \_\_\_\_\_ Does your child suck her/his thumb? Yes \_\_\_ No \_\_\_ If no, did she/he? \_\_\_\_\_  
Does your child drool? Yes \_\_\_ No \_\_\_ Does your child take a bottle? Yes \_\_\_ No \_\_\_  
If no, what age was it weaned? \_\_\_\_\_

**Food Diary**

(Please fill out completely.)

Does your child wake at night to eat? \_\_\_ Describe: \_\_\_\_\_

**Day 1: Breakfast** \_\_\_\_\_  
\_\_\_\_\_

Lunch \_\_\_\_\_  
\_\_\_\_\_

Dinner \_\_\_\_\_  
\_\_\_\_\_

Snacks (time of day) \_\_\_\_\_

Approximate amount of solids per day \_\_\_\_\_, fluids per day \_\_\_\_\_

**Day 2: Breakfast** \_\_\_\_\_  
\_\_\_\_\_

Lunch \_\_\_\_\_  
\_\_\_\_\_

Dinner \_\_\_\_\_  
\_\_\_\_\_

Snacks (time of day) \_\_\_\_\_

Approximate amount of solids per day \_\_\_\_\_, fluids per day \_\_\_\_\_

**Day 3: Breakfast** \_\_\_\_\_

\_\_\_\_\_

Lunch \_\_\_\_\_

\_\_\_\_\_

Dinner \_\_\_\_\_

\_\_\_\_\_

Snacks (time of day) \_\_\_\_\_

Approximate amount of solids per day \_\_\_\_\_, fluids per day \_\_\_\_\_

Favorite foods: \_\_\_\_\_

Least favorite foods: \_\_\_\_\_

List foods that your child used to eat now refuses: \_\_\_\_\_

Please check all that apply to your child:

- Tolerates unliked foods on his/her plate
- Chokes or coughs during meals
- Stuffs mouth
- Self feeds
- Doesn't tolerate food on hands or face
- Doesn't chew
- Will try any new food at least once
- Picky eater
- Difficult to feed
- Eats less than 20 different foods
- Refuses to sit during entire meal
- Eats food from all food groups
- Places too much food in mouth at a time
- Refuses food group or texture
- Swallows food whole
- Engages in mealtime battles
- Has sensory processing difficulties