OT 4 KIDs
Feeding and Food Aversion Questionnaire

Child's name: _____
Age:_____

Does your child have any food allergies or special dietary considerations that we should be aware of?_____Please provide details:

What is your primary concern about your child's eating issues?

What is your primary goal for child in our program?

Please list your child's favorite foods:

Please list 5 target foods that you would like your child to be able to eat as an outcome of our program in order of preference"

1
2
3
4
5

How much time do you spend with our child during meals?

How much time do you spend planning, thinking, preparing, and worrying about what to feed your child at a typical meal?

How do your child's eating problems affect mealtime and family life? (Relationships with your child, spouse and other family members?)

If you have other children do you think your child's struggle with meal times affects your other children? In what ways?

Do your child's eating issues affect social occasions, vacations and your ability to eat out?

Do any of the following apply to your concerns about your child's eating difficulties:

- Weight gain or growth
- Nutritional intake
- Social participation with family and peers in meal time
- Speed and efficiency of eating
- Having a typical family mealtime experience
- Being able to eat out at restaurants without worry

Additional comments: