Dear Parent/Guardian,

In an effort to provide the most appropriate therapy(ies) to your child, please take a moment to answer the following questions. Please return this completed questionnaire to the front desk at your child’s next visit. Thank You.

1). Child’s Name________________________ Your Name__________________________________________

3). Does your child have any aversions to certain food textures? __________________________ if yes, please describe_____________________________________________________________________________

________________________________________________________________________________________

4). Does your child have any feeding peculiarities (packing mouth overfull, drink extraordinary amounts of beverage with a meal, inappropriate/uncoordinated tongue movements, etc)? If yes, please describe__________________________________________

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5). Does your child appear to have any difficulty with eating ( trouble swallowing, choking, gaging or vomiting at mealtime)? If yes, please explain ____________________________________________________________

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