GOLISANO CHILDREN'S HOSPITAL

Developmental and Behavioral Pediatrics

UR MEDICINE
MEDICINE of THE HIGHEST ORDER

Feeding Disorders Program New Patient Questionnaire

Dear Parent/Caregiver:

To get ready for your child's feeding evaluation, we need you to do two things:

1. **Get information from your child's pediatrician**:
    a. Growth Charts (height, weight, and head circumference)
    b. Lab Work
    c. Please have them fax this to us BEFORE your appointment @ 585-742-4217
2. **Complete the enclosed forms**: There is a questionnaire that gathers detailed information about your child's feeding history, food preferences, and current mealtime routines. There are also several surveys assessing the severity of disruptive behaviors at mealtimes and the impact of his/her behaviors on the family. Please answer all questions, even if they do not seem to apply to your child. Please complete all the forms and send them back BEFORE your visit. If you are seeing the dietician, be as specific as possible when completing the Three Day Food Record, and list all food and drinks your child eats for the 3 days. If we do not receive this before your appointment it may be rescheduled.

What to expect during your visit

1. You and your child will come to discuss your child's feeding problems and review the forms, so we can get a clear understanding of all of your concerns.
2. During this visit, we will observe your child eat a meal/snack. Please bring the following:
    - A preferred food
    - A food your child used to eat, but has dropped from their diet recently
    - A food that is similar to a preferred food but your child is not yet eating
    - A new food you would like to see your child try
    - You should also bring any preferred cups, plates spoons, etc. as needed. At the end of this visit, we will discuss additional services and/or options for outpatient therapy.
    - If you are seeing the Speech Therapist, you should bring foods with various textures, and a drink
3. For telemedicine visits, we cannot conduct any sessions while you are driving in the car or in other public places. We need your focus and attention in order to serve you and your family with the best level of care.

We look forward to meeting you and your child,

The Pediatric Feeding Disorders Team

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www.golisano.urmc.edu/dbp

Child's name _____ Child's date of birth _____

Child's address _____ Date form completed _____

Insurance Carrier Policy Number

Persons Completing Form

Name	Relationship to child	Does the child live with you?	Phone numbers
	☐ Biologic parent ☐ Foster/adoptive parent ☐ Relative ☐ Guardian ☐ Other	☐ Yes ☐ No	(H) (C) (W)
	☐ Biologic parent ☐ Foster/adoptive parent ☐ Relative ☐ Guardian ☐ Other	☐ Yes ☐ No	(H) (C) (W)
Parent/Guardian Marital Status	☐ Married ☐ Divorced ☐ Separated ☐ Unmarried ☐ Widowed		

Home Information

Please list all adults and children who live at home with this child.

Name	Age	Relationship to child	Occupation or grade in school	Has this person ever been seen in Developmental & Behavioral Peds?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Are there any living arrangements (for example, shared custody or foster care), custody issues, parental disagreement about care, or orders of protection that we should be aware of?

Daycare/School Information

Current daycare	
Daycare address	
Daycare phone number	
Current school/preschool	
School address	
School phone number	

Feeding/Eating Information

Please describe your **concerns** about your child's eating.
What are your **goals** for your child's eating?

Health History

Are any of the following health concerns a problem for the child currently or were a past concern?

Concern	Currently	Never	In the past
Developmental delays or mental health concerns (ASD, ADHD, anxiety)	☐	☐	☐
Head injury, seizures, or other cranial nerve problems	☐	☐	☐
Vision problems	☐	☐	☐
Ear problems (infections, hearing, or other)	☐	☐	☐
Dental problems	☐	☐	☐
Heart conditions	☐	☐	☐
Asthma, needs oxygen, or other lung problems	☐	☐	☐
Nausea or vomiting	☐	☐	☐
Gastroesophageal Reflux (GERD)	☐	☐	☐
Eosinophilic Esophagitis (EoE)	☐	☐	☐
Delayed gastric emptying	☐	☐	☐
Diarrhea (loose, watery stools)	☐	☐	☐
Constipation (hard, painful stools)	☐	☐	☐
Stomach/abdominal pain	☐	☐	☐
Kidney/bladder problems	☐	☐	☐
Anemia (low blood counts)	☐	☐	☐
Skin problems (eczema, rashes)	☐	☐	☐
Allergies to food or medicine	☐	☐	☐

Genetic disorder	☐	☐	☐
Behavior Concerns (home, school)	☐	☐	☐
Health concern not listed above	☐	☐	☐

If you selected any of the boxes above, please describe…

Please list any additional developmental concerns.

Has your child ever had any procedures to evaluate feeding, swallowing, or GI function?

☐ Swallow study ☐ Upper GI ☐ Endoscopy ☐ Gastric emptying study ☐ Abdominal x-ray

☐ EEG ☐ MRI ☐ Other

Does your child currently use a feeding tube? ☐ Yes ☐ No **Did your child use a feeding tube in the past?** ☐ Yes ☐ No

If yes, please complete the following:

Please list the dates the tube was placed, removed

Name of formula	
Type of feeding Tube	☐ NG (nasogastric) ☐ G-tube ☐ Gastrostomy-Jejunostomy (GJ tube)
Type of feedings	☐ Bolus ☐ Continuous ☐ Pump ☐ Gravity
Amount per hour (rate)	
Total volume given per feeding each day	
Total volume per day	
Vomiting or other problems during tube feedings?	☐ No ☐ Yes If yes, please list:

Schedule:

Time	Amount	Place (home, school, etc)

Labor and Delivery

Birth mother's age at birth of child _____ Birth father's age at birth of child _____

Birth weight _____ Birth length _____ Birth head circumference _____

What was the length of the pregnancy (gestational age)? _____ months or _____ weeks

Was this child…	☐ Single birth ☐ One of twins ☐ One of triplets ☐ Other multiple
Was this child born by…	☐ Vaginal delivery ☐ Cesarean section
Please describe any labor/delivery complications.	
Was your child admitted to the Special Care Nursery or NICU (neonatal ICU)?	☐ Yes ☐ No ☐ Unsure
If "Yes", please describe…	
How old was your child when discharged from the NICU?	

Feeding History

How was your child fed during infancy?	☐ Breast ☐ Bottle ☐ Both ☐ Not fed by mouth
Did you child have problems with breast or bottle feeding?	☐ Yes ☐ No ☐ Unsure
If "Yes", please describe…	
Age when baby foods were given	
Age when table foods were given	
How did your child respond to these foods?	
At what age did you first notice your child had a feeding problem?	

Allergy and Nutrition

Please list any food allergies.	
Any food allergies in the family?	
Please list any food restrictions or cultural considerations.	
Please describe any difficulty you have had in the past year in getting food for your family.	
Please list any vitamins/supplements you give your child.	

Feeding Skills and Abilities

Please select any items that are a problem during feeding:

☐ Chewing ☐ Using tongue to move food ☐ Gagging ☐ Coughing ☐ Vomiting ☐ Choking ☐ Problems drinking
☐ Problems swallowing ☐ Overstuffing food ☐ Holding food in mouth ☐ Eats too fast ☐ Eats too slow
☐ Drooling ☐ Tongue thrust ☐ Poor suck ☐ Poor lip closure ☐ Loses food/fluid from mouth while eating

Do the above problems occur with ☐ All foods ☐ Certain types/textures

Has your child ever needed thickened liquids?	☐ Yes ☐ No
Has your child ever needed foods to be pureed?	☐ Yes ☐ No
Are you worried about aspiration (food/liquid going into the child's lungs)?	☐ Yes ☐ No
Has your child ever choked and needed the Heimlich?	☐ Yes ☐ No ☐ Unsure

Self-Feeding

Which of the following describes your child's feeding?

☐ Bottle or breast fed only ☐ Parent spoon-feeds child ☐ Child uses his/her fingers to eat
☐ Child feeds him/herself, but needs adult help ☐ Child feeds him/herself independently

Tell us about the following utensils your child uses.

Utensil	Does not use	Uses, with adult help	Uses independently
Spoon	☐	☐	☐
Fork	☐	☐	☐
Straw	☐	☐	☐
Open cup	☐	☐	☐
Sippy cup	☐	☐	☐
Baby bottle	☐	☐	☐
Water bottle	☐	☐	☐

Current Feeding Routines

What does your child sit on to eat? (Select all that apply)	☐ High chair ☐ Booster seat ☐ Regular table and chair ☐ Child's table and chair ☐ On adult lap ☐ Lying down ☐ Couch ☐ Floor ☐ Bed ☐ Other
Where in the house does he/she sit?	☐ Kitchen ☐ Dining room ☐ Living room ☐ Bedroom ☐ In front of TV/computer ☐ Walking around the house ☐ Other:
Who does your child eat with?	☐ By him/herself ☐ Siblings ☐ Peers ☐ Other family members
How long does your child sit for a usual meal or snack?	
Does your child stay seated during meals?	☐ Yes ☐ No
Does your child have a usual meal and snack schedule?	☐ Yes ☐ No

Please list the most typical times.

Meal/snack	Time	Location (home, school, etc.)	Food/drink typically offered

Does your child seem to want to snack between meals?	☐ Yes ☒ No
Does your child have access to their foods? If so, where is it kept?	☐ Yes ☒ No
Does your child eat better in different places or with different people?	☒ Yes ☐ No

If yes, please describe…

Family members:

School/daycare:

Restaurants:

Parties/sleepovers:

Food Selectivity Concerns

What textures does your child like best? (select all that apply)

☐ Dry ☐ Crunchy ☐ Soft ☐ Wet/sticky ☐ Smooth foods/pureed foods ☐ Single texture

☐ Mixed texture (e.g., pizza, tacos, soup) ☐ Other:

What flavors does your child like best? (select all that apply)

☐ Bland ☐ Sweet ☐ Salty ☐ Spicy ☐ Savory ☐ Sour/Bitter ☐ Likes Strong Flavors ☐ Other:

Brand or container preferences	
Food preparation preferences	
Temperature, shape, or color preferences	
Specific utensils or cups needed	
Rules or rituals about foods	

Mealtime Behavior

Please select all of the behaviors your child shows during mealtimes.

☐ Screams/cries ☐ Says "no" ☐ Yells, argues ☐ Turns head away ☐ Pushes food away ☐ Spits food out

☐ Refuses to come to the table ☐ Leaves the table ☐ Holds food in mouth ☐ Eats too slow or fast ☐ Tantrums

☐ Gags/vomits with non-preferred foods ☐ Other:

When you offer a new food, at what point does your child begin to get upset?

☐ When we talk about it ☐ When he/she sees the food ☐ When he/she smells the food ☐ When food is put on the table

☐ When food is put on his/her plate ☐ When he/she touches it ☐ When he/she tastes it

☐ Other:

Behavior Management

Preventing disruptive behaviors:

☐ Talking about food ☐ Offering choices ☐ Playing with toys ☐ Watching TV ☐ Positive attention ☐ Offer preferred foods

☐ Give a new food at each meal ☐ Cook separate meals ☐ Mix nonpreferred foods in with preferred foods ☐ Shopping

☐ Help with cooking ☐ Offer similar foods to what they already eat ☐ Visual supports ☐ Remove Distractions

☐ Leave food out during the day

Expectations: ☐ Try one bite ☐ Eat what the family eats ☐ Stay at the table until everyone is finished ☐ No mealtime rules

Consequences: ☐ Offer rewards (like playing a game after the meal, extra game time, go outside) ☐ First/then

☐ Touch-Smell-Kiss-Lick- Bite strategy ☐ Taking away privileges ☐ Time out ☐ Force food in mouth

☐ No snack if meal isn't eaten ☐ Bedtime snack if dinner isn't eaten ☐ Not offering new foods at this time

☐ Other strategies you have tried:

Therapies:

Has your child received feeding therapy before?	☐ Yes ☐ No ☐ Unsure
If yes, where and what was the therapist's name?	
Does your child currently receive any therapies?	☐ Yes ☐ No ☐ Unsure

Type	Receiving?	Therapist name	Agency/location	Is therapist working on feeding?
Speech	☐ Yes ☒ No			☐ Yes ☒ No
Occupational therapy	☒ Yes ☐ No			☒ Yes ☐ No
Physical therapy	☐ Yes ☐ No			☐ Yes ☐ No
Nutrition	☐ Yes ☐ No			☐ Yes ☐ No
Special education	☐ Yes ☐ No			☐ Yes ☐ No
Psychologist	☐ Yes ☐ No			☐ Yes ☐ No
Other: Specify Other Therapy	☒ Yes ☐ No			☐ Yes ☐ No

Feel Free to list any other concerns you have in the space below:

Updated 4/4/2022

Food Preference Checklist

Child's name _____

How would you rate your child's appetite on a scale of 1 (poor) to 10 (eats too much)? _____

Please select all foods your child <u>currently eats</u> and label any specific brands.

Starches

- ☐ Bread
- ☐ Oatmeal
- ☐ French fries
- ☐ Mashed potatoes
- ☐ Spaghetti
- ☐ Rice
- ☐ Noodles
- ☐ Corn
- ☐ Baked potatoes
- ☐ Waffles
- ☐ Pancakes
- ☐ Cereal (list brands)
- ☐ French toast
- ☐ Muffins
- ☐ Macaroni and cheese

Fruits

- ☐ Orange juice
- ☐ Apple juice
- ☐ Grape juice
- ☐ Watermelon
- ☐ Raisins
- ☐ Peaches
- ☐ Pears
- ☐ Pineapple
- ☐ Oranges
- ☐ Bananas
- ☐ Strawberries
- ☐ Berries
- ☐ Apples
- ☐ Applesauce
- ☐ Grapes

Vegetables

- ☐ Green beans
- ☐ Cucumber
- ☐ Peas
- ☐ Spinach
- ☐ Broccoli
- ☐ Lettuce/salad
- ☐ Tomatoes
- ☐ Carrots
- ☐ Sweet potatoes

Milk/Dairy

- ☐ Cheese
- ☐ Soy/almond milk
- ☐ Pudding
- ☐ Ice cream
- ☐ Milk (whole, 1 or 2 %)
- ☐ Chocolate/flavored milk
- ☐ Yogurt (list type)

Meat/Protein

- ☐ Chicken
- ☐ Chicken nuggets
- ☐ Sausage
- ☐ Pork
- ☐ Other:
- ☐ Fish
- ☐ Fish sticks
- ☐ Ham
- ☐ Nuts
- ☐ Eggs
- ☐ Hamburger
- ☐ Peanut butter
- ☐ Roast beef
- ☐ Steak
- ☐ Turkey
- ☐ Hot dogs

Mixed Textures

- ☐ Pasta with sauce
- ☐ Tacos/burritos
- ☐ Pizza
- ☐ Casseroles
- ☐ Peanut butter & jelly
- ☐ Soup
- ☐ Grilled cheese

Extras

- ☐ Margarine
- ☐ Salad dressing
- ☐ Other:
- ☐ Syrup
- ☐ Jelly
- ☐ Mayonnaise
- ☐ Mustard
- ☐ Cream cheese
- ☐ Ketchup

Snacks

- ☐ Cookies
- ☐ Goldfish
- ☐ Veggie sticks
- ☐ Pretzels
- ☐ Crackers
- ☐ Chips
- ☐ Water
- ☐ Soda
- ☐ Kool-Aid
- ☐ Pop Tarts
- ☐ Fruit Snacks
- ☐ Granola Bars

Please list any foods you cook at home that aren't on this list.

Please list any foods your child used to eat but doesn't eat anymore (within the last 6 months).

How much (in ounces) of the following liquids does your child drink each day?

Milk _____ Water _____ Juice _____ Soda _____

Breastmilk _____ Formula _____ Other _____

ABOUT YOUR CHILD'S EATING

Version 02 / Oct 08, 2014

AYCE

Child's Name: _____ **Child's Birthdate:**_____

Caregiver Name:_____ **Relationship to child**: _____

A variety of situations take place in families around children's eating.
Please indicate how often each of the following occurs between you and your child or in your family.

	Never	Once in a while	Sometimes	Often	Nearly every time
1. My child hates eating	■ 1	2	3	4	5
2. I feel like a short-order cook because I have to make special meals for my child.	1	2	3	4	5
3. Meal times are among the most pleasant in the day.	1	2	3	4	5
4. I feel that it is a struggle or fight to get my child to eat.	1	2	3	4	5
5. My child refuses to eat.	1	2	3	4	5
6. I worry that my child will not eat right unless closely supervised.	1	2	3	4	5
7. My child is a picky eater.	1	2	3	4	5
8. The family looks forward to meals together.	1	2	3	4	5
9. My child enjoys eating.	1	2	3	4	5
10. Mealtime is a pleasant, family time.	1	2	3	4	5
11. I get pleasure from watching my child eating well and enjoying his/her food.	1	2	3	4	5
12. I dread meal times.	1	2	3	4	5
13. We have nice conversations during meals.	1	2	3	4	5
14. Meal times are the pits.	1	2	3	4	5
15. It is hard for me to eat dinner with my child because of how he/she behaves.	1	2	3	4	5
16. There are arguments between me and my child over eating.	1	2	3	4	5
17. My child seems to have no appetite.	1	2	3	4	5
18. My child has mealtime tantrums.	1	2	3	4	5
19. My child refuses to eat a planned meal.	1	2	3	4	5
20. I have to force my child to eat.	1	2	3	4	5
21. I use preferred foods (such as dessert) as rewards or bribes to get my child to eat "good" foods	1	2	3	4	5
22. We watch television during meals.	1	2	3	4	5

ABOUT YOUR CHILD'S EATING

Version 02 / Oct 08, 2014

AYCE

	Never	Once in a while	Sometimes	Often	Nearly every time
23. There are house rules about how much kids have to eat (for example, the "Clean Plate Club"; No dessert until you eat what's on your plate).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
24. I have thought about putting my child on a diet.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
25. We end up grabbing meals whenever we can with no time for planning.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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PARDI-AR-Q: Parent 4+

The following questions are about your child's eating – some ask about how things currently are, others ask about things over the past month or the past 3 months. Please tick the boxes that apply, or enter the information requested. **Please read each question carefully. Please answer all the questions. Thank you.**

6. Do you think your child has a problem with eating, involving avoidance or restriction of foods or their eating overall? Yes ☐ No ☐

7. Have other people (for example, doctors, family members, significant others) said that your child has a problem with eating, involving avoidance or restriction of foods or their eating overall? Yes ☐ No ☐

8. Have your child's eating habits led to difficulty maintaining a sufficient weight or, if they are still growing, difficulty gaining enough weight to keep pace with their growth? Yes ☐ No ☐

9. Have your child's eating habits led to them losing weight (in other words, if they have lost weight, this is because of avoidance or restriction and not because of a medical illness, or other reason)? Yes ☐ No ☐

10. If yes to #9 above, how much weight have they lost in the past 3 months? (please enter numbers): lbs ☐ **/OR** stones ☐ lbs ☐ **/OR** kg ☐ **OR** No weight loss over past 3 months ☐

11. Have others (for example, doctors, family members) been concerned about your child's weight loss, or been concerned that they are having difficulty gaining enough weight to grow, or having difficulty maintaining their weight due to their eating habits? Yes ☐ No ☐

12. Have others (for example, doctors, family members) been concerned that your child is not growing taller as they should due to their eating habits? Yes ☐ No ☐ My child has finished growing ☐

13. Have you ever been told by **any health professional** that due to their eating habits your child is not growing as expected, or that their height was less than it should be? Yes ☐ No ☐

14. Over the past month, has **any health professional** said that your child has a nutritional deficiency due to their eating habits (for example, low iron, low vitamin B12, low vitamin C)? Yes ☐ No ☐

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15. Over the past month, has **a healthcare professional prescribed** special supplements (for example, pills, capsules, powders, or drinks containing vitamins and/or minerals and other micronutrients) **specifically to help with your child's nutrition?** Yes ☐ No ☐

16. If yes to #15 above, what has been prescribed and how much does your child take each day?

_____

17. Over the past month, has **a healthcare professional prescribed** special supplements (for example, high-calorie drinks or 'shots', or dessert-style high-calorie supplements) **specifically to help your child maintain or gain weight?** Yes ☐ No ☐

18. If yes to #17 above, what has been prescribed and how much does your child take each day?

_____

19. Is your child currently receiving any tube feeding (receiving food or fluid via a tube in their nose or into their stomach)? Yes ☐ No ☐

20. If yes to #19 above, what is the name of the **food or fluid product taken via the tube** and how much does your child take each day?

_____

21. Does your child's eating cause them difficulties in daily functioning - that is, in how they are able to go about things each day? This might be at school/college/work or when at home. Yes ☐ No ☐

22. Does your child's eating cause them difficulties in interactions with other people (for example, disagreements or arguments with parents, siblings, significant others), or difficulty making or sustaining friendships or other close relationships?
Please circle a number on the line below how difficult **interactions with other people** are for your child because of their eating, ranging from 0 (= no difficulty) to 6 (= extremely difficult)

0 1 2 3 4 5 6

23. Does your child's eating cause them difficulties in social situations, for example does it make it difficult for them to go out with friends, eat at school/college, or stay away from home?

Please circle a number on the line below how difficult **social situations** are for your child because of their eating, ranging from 0 (= no difficulty) to 6 (= extreme /tries to avoid all social situations)

0 1 2 3 4 5 6

24. Over the past month, has your child been particularly sensitive to variation in taste (for example, noticing slight differences in the taste of foods), which has put them off eating any foods or trying any new foods?

Please circle a number on the line below how much **sensitivity to taste** has affected your child's eating, ranging from 0 (= no negative effect/no particular sensitivity to taste) to 6 (= extremely negative effect, for example, leading to refusal to eat many foods, sticking only to a limited number of preferred foods, or extreme caution when eating)

0 1 2 3 4 5 6

25. Over the past month has your child been particularly sensitive to the texture or consistency of food, which has put them off eating any foods or trying any new foods (for example, does your child stick to foods of a certain texture only or have they had difficulty eating foods that have different textures mixed together such as pasta with sauce or sandwiches)?

Please circle a number on the line below how much **sensitivity to texture or consistency** has affected your child's eating, ranging from 0 (= no negative effect/no particular sensitivity) to 6 (=extremely negative effect, for example, leading to refusal to eat many foods, sticking only to a limited number of preferred foods, or extreme caution when eating)

0 1 2 3 4 5 6

26. Over the past month, has your child been particularly sensitive to the appearance of food, which has put them off eating any foods or trying any new foods (for example, if food does not look "right", such as burnt ends of chips/fries, broken biscuits/cookies, or being the "wrong" colour)?

Please circle a number on the line below how much **sensitivity to the appearance of food** has affected your child's eating, ranging from 0 (= no negative effect/no particular sensitivity) to 6 (=extremely negative effect, for example, leading to refusal to eat many foods, sticking only to a limited number of preferred foods, or extreme caution when eating)

0 1 2 3 4 5 6

27. Over the past month, how often has your child forgotten to eat or found it difficult to make time to eat?

Please circle a number on the line below how often your child has **forgotten to eat or found it difficult to make time to eat**, ranging from 0 (= never) to 6 (=always)

0 1 2 3 4 5 6

28. Over the past month, how often has your child appeared to lack enjoyment in food or eating (even if only certain foods)?

Please circle a number on the line below how often your child has **lacked enjoyment in food or eating**, ranging from 0 (= never) to 6 (=always)

0 1 2 3 4 5 6

29. Over the past month, how often has your child said or indicated they are full before their meal is finished, or stopped eating sooner than others because they had had enough?

Please circle a number on the line below how often your child has **indicated they are full or stopped eating early**, ranging from 0 (= never) to 6 (=always)

0 1 2 3 4 5 6

30. Over the past month has your child been avoiding or restricting the amount or type of food they eat, because they have said or indicated they were afraid that something bad might happen, like being sick, choking, having an allergic reaction, or being in pain?

Please circle a number on the line below how often being **afraid something bad might happen** has affected your child's eating, ranging from 0 (= never) to 6 (=always)

0 1 2 3 4 5 6

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31. Over the past month has your child avoided eating situations because they said or indicated they were worried something bad might happen, like being sick, choking, having an allergic reaction, or being in pain while eating (for example, because they might be served something they usually avoid for these reasons, or because they have had a bad experience in the past)?

Please circle a number on the line below how often your child has **avoided eating situations** due to such worries, ranging from 0 (= never) to 6 (=always)

0 1 2 3 4 5 6

32. Over the past month has your child expressed any physical feelings of panic or anxiety (examples might include a racing heart, sweaty palms, feeling sick) when they have seen something that has made them think something bad might happen, like being sick, choking, having an allergic reaction, or being in pain while eating

Please circle a number on the line below how often your child had **had physical feelings of panic or anxiety** due to such thoughts, ranging from 0 (= never) to 6 (=always)

0 1 2 3 4 5 6

THANK YOU!