The PEACH Survey

Parent Eating and Nutrition Assessment for Children with Special Health Needs

Child's Name: _____ Date of Birth: _____

Parent/Caregiver: _____ Date: _____

Address: _____ Phone Number: _____

Please Circle YES or NO for each question as it applies to your child:

Does your child have a health problem (do **not** include colds or flu)? YES NO (1)

Is your child: Small for age? ___ Too thin? ____ Too heavy? ____ YES NO (3)

Does your child have feeding problems? YES NO (3)

If YES, what are they? _____

Is your child's appetite a problem?: YES NO (1)

Is your child on a special diet?: YES NO (2)

If YES, what type of diet? _____

Does your child take medicine for a health problem?: YES NO (1)

(do not include vitamins, iron, or fluoride)

If YES, name the medication/s _____

Does your child have food allergies? YES NO (1)

If YES, what are they? _____

Does your child use a feeding tube or other special feeding method? YES NO (4)

If YES, explain: _____

Circle YES if our child does **not** eat any of these foods: YES NO (1)

(check all that apply) milk __ meats __ vegetables __ Fruits __

Circle YES if your child has problems with: YES NO (3)

(check all that apply) Sucking ___ Swallowing ___ Chewing ___ Gagging ____

Does your child eat clay, paint chips, dirt, or any other **things** that are not food? YES NO (3)

If YES, what is it? _____

Does your child refuse to eat, throw food, or do other things that upset your mealtimes? YES NO (2)

If YES, explain: _____

For infants **under** 12 months old who are bottle fed:

Does your child drink less than 3 (8 – ounce) bottles of milk each day? YES NO (1)

For children **over** 12 months (Check if applies and circle YES) YES NO (1)

Is your child **not** using a cup? ___ Is your child **not** finger feeding? ___

For children **over** 18 months:

Does your child still take most liquids from a bottle? YES NO (2)

Circle YES if your child is **not** using a spoon. YES NO (2)

(To be scored by staff and reviewed.)