Supplemental Material S1. Developmental Questionnaire.

Child's name: _____ Date of birth: _____
Date form was completed: _____

When did your child begin to do the following? Please state the age in months. Please place an X in the Not yet column if your child does not currently have the skill listed.

Skill	Age (months)	Not yet
Roll		
Sit on own		
Crawl		
Pull self up along furniture		
Walk along furniture		
Walk on own		
Coo (vocalize, vocal play)		
Babble (random sounds)		
1ST meaningful word		

Please choose the answer that best describes the frequency with which you child does the following behaviors. Please place an X in the appropriate box. If you have not observed the behavior, or the item does not apply to your child, please put an X in the Never column.

Please use the following key when responding.

Always: When presented with the opportunity your child always responds in this manner.
Frequently: responds this way about 75% of the time
Occasionally: responds this way about 50% of the time
Seldom: responds this way about 25% of the time
Never: responds this way 0% of the time

Item	Oral Sensitivity	Always	Frequently	Occasionally	Seldom	Never
1	Suck thumb					
2	Use pacifier					
3	Put hands in mouth					
4	Put toys in mouth					
5	Gag with things in his/her mouth					
6	Excessive drooling without teething					

When did your child begin to eat the following foods? Please be as specific as possible. Circle Y for Yes if there were problems starting these foods and N for No if there were no problems starting these foods.

Age (months) started foods:	**Problems (describe):**
Bottle _____	Y N _____
Cereal by spoon _____	Y N _____
Fruits/vegetables _____	Y N _____
Stage 3 (smooth) _____	Y N _____
Stage 3 (lumpy/textured) ____	Y N _____
Finger foods _____	Y N _____
Table foods_____	Y N _____
Cup_____	Y N _____

When healthy (not during illness), has your child ever had problems with the following items or does your child currently have problems with the following items during mealtime? Please mark an X in the boxes that described/s your child.

Item	In the past	Now	Does not apply
Slow feeder			
Takes small quantities			
Gagging			
Coughing			
Choking			
Refuses bottle			
Refuses formula			
Refuses cup			
Refuses foods from spoon			
Refuses solids			
Difficulty chewing solids			
Difficult to get into feeding routine			
Feeds on demand			
Does not eat enough			
Refuses to eat food offered			
Choosy or picky about food			
Definite likes and dislikes			
Refuses food with lumps or texture			

Please place an X in the boxes which best describe your child's current feeding status.

Please see the following examples*.

Stage 3 textured: puree with pieces of solids or lumps
Adult puree: applesauce, pudding, yogurt etc.
Dissolvable solids: foods that melt in your mouth with minimal chewing (i.e., graham crackers, butter crackers, Gerber puffs, Cheeto puffs)
Soft / well-cooked: soft vegetables, meats etc.
Crunchy: crisp crackers, chips etc.
General table food: foods that the parents eat cut into small pieces

Food item	Yes	No	# of times given per day
LIQUIDS			
Breast			
Bottle			
Formula			
Breast milk			
Juice			
PUREES			
Stage 1			
Stage 2			
Stage 3 smooth			
Stage 3 textured*			
Adult puree*			
SOLIDS			
Dissolvable*			
Soft / well-cooked*			
Crunchy*			
General table food*			
CUP			
Sipper cup (not spill-proof)			
Sipper cup with valve (spill-proof)			
Open / regular			
Straw			