Occupational Therapy Eating, Oral Care and Oral-Motor Assessment Data

Individual:	**Date(s) of Assessment:**
Therapist/Agency:	**Contact Information:**
Diagnosis:	Reason for referral:
Meal and other activities Observed:	Support Personnel/Family Assisting:
(Check items that apply)	
Eating and Oral-Motor Observations/Data	**Comments** (*circle areas/items for treatment consideration*)

Tube-fed?		Dependently fed?		Self-feeding?	

Tube feeding method/schedule	☐ Has some oral intake ☐ Bolus ☐ Drip-feedings Tube-feeding schedule:
Environmental Factors	Other observations: Comments

Loud		Yes		No	Busy		Yes		No
Bright		Yes		No	Rushed		Yes		No
Positive Interaction		Yes		No	Assists-Meal Prep		Yes		No

General Level of Alertness	
Responds to cues	
Average Time Needed to complete meal:	
Mealtime Communication: Interactions? Choices?	

Mealtime Plan in place?		Yes		No	Plan followed by staff/family?
Positioning Plan in place? CARMP in place?		Yes Yes		No No	Plan followed by staff/family? Plan followed by staff/family?

Client Positioning	*Describe W/C or other positioning at and around mealtimes and/ or positioning during tube-feeding*
	Trunk :
	UE/LE:
	Head Neck:
	Other:
General Observations	Trunk Tone:
	Primitive Reflexes (ATNR, etc)
	UE Tone:
	Head Control:
	Oral Tone:
	Oral Structural Abnormalities:
Provider Position (if Applicable)	

Hx. of Aspiration?		Yes		No	Swallowing Study:		Yes		No	Date: Location:
Hx. of GERD?		Yes		No	Upper GI:		Yes		No	Date: Location:

Comments/Results:

Breathing Patterns	Mouth breather? Nasal Congestion? Labored Inhalation?

Weight Concerns?		Yes		No	
Special Diet/Nutritional?		Yes		No	

Food Consistency:		Hx. Of Choking?		Yes		No	
Liquid Consistency:		Hx of Rumination?		Yes		No	

Eating and Oral-Motor Observations/Data	**Comments** (*circle areas/items for treatment consideration*)

	Rooting		Bite Reflex		Tongue Thrust		Strong Gag Reflex		Suckling		Suck/swallow
	Maintains food/drink in mouth				Loss of food/drink						
	Achieves/Maintains Lip Closure				Poor Lip Closure		Around spoon/cup? At rest?				
	No or minimal Drooling				Mod/Severe Drooling		During chewing? At rest?				
	Sucks from cup				Sucks from spoon						
	Rotary Chewing Movements				Vertical Chewing						

	Poor bolus formation		Protruding tongue	
	Graded Jaw Movement		Ungraded Jaw Movement	
	Ant./Posterior Tongue Movement		Lateral Tongue Movement	
	Swallowing – Initiation WFL		Swallowing - Delayed	Repeated Swallows?
	Clears Oral Cavity after swallow		Residue noted	Where?
	Normal Dentition		Missing Teeth	Edentulous? Dentures?
	Oral Hygiene appears good		Appears poor	Oral Pain/Swelling/redness?
	Oral Hypersensitivity		Oral Hyposensitivity	Describe: (Startles? Refuses? Facial Expressions? Varies with texture/presentation? Inside and/or Outside Mouth? Seeks oral input? Mixed?)
	Behaviors - Appropriate		Risky Mealtime Behaviors Noted	Describe: (Rate, Bite-Size, Stuffing Mouth, Binging, Rumination, Food selectivity, Refusal, Rigid Eating Routines, etc…)

POSSIBLE SIGNS/SYMPTOMS OF ASPIRATION					Comments
Coughing during meal		Yes		No	Appears productive? Signs of struggle with cough? On what consistencies?
Coughing after meal		Yes		No	
Choking/gagging during or after meal		Yes		No	
Wet or "gargly" vocal quality		Yes		No	
Wheezing (w/o asthma)		Yes		No	
Shortness of breath		Yes		No	
Fast or labored breathing		Yes		No	
Bluish lips or fingernails		Yes		No	
Frequently "clears throat"		Yes		No	
Frequent vomiting or regurgitation		Yes		No	
Fearful of eating/drinking		Yes		No	
Smell formula on breath		Yes		No	
Watery eyes during eating		Yes		No	
Increased mucous		Yes		No	
Excessive fatigue during eating/drinking		Yes		No	
Unexplained significant weight loss		Yes		No	
Frequent low grade fevers		Yes		No	
Hx. of Pneumonia		Yes		No	

Other Comments:

FUNCTIONAL PERFORMANCE SKILLS		**EATING/DRINKING**		
DAILY LIVING SKILLS (Note: some items may be assessed per staff report)	**Key:**	I = Independent V/G = Verbal/Gestural Assistance P = Physical Assistance	D =Dependent N/A = not applicable NT = not tested/reported	* = with Assistive Technology Place star next to level number if individual completes this level with AT.

SKILL		**LEVEL**	**COMMENTS** *(include Assistive Technology if applicable)*
Holds glass/cup			
Drinks from glass/cup			
Uses Straw			
Maintains grasp of spoon			
Scoops food			
Brings food to mouth			
Removes food from spoon			
Uses fork			
Uses knife			
Uses napkin			
Other			
Other			

FUNCTIONAL PERFORMANCE SKILLS		**Tooth Brushing**
SKILL	**LEVEL**	**COMMENTS** *(include Assistive Technology if applicable)*
Squeezes Toothpaste		
Grasps Toothbrush (TB)		
Brings TB to mouth		
Moves Toothbrush effectively		
Brushes all Surfaces		
Brushes Tongue		
Spits out excess saliva or tooth paste		
Uses Floss effectively		
Uses Mouthwash or rinses with water effectively		
Cleans off TB		
Other		

TOOTH BRUSHING OBSERVATIONS												
Comments/Data: *(circle areas/items for treatment consideration)*												
Type of tooth brush used	Other (if not below):											
		Manual/Type		Soft/Med Bristles		Electric TB/Type		Suction TB/Type		Timed TB		Tri-Head TB
		Sensitivity TB		Dex-T TB		Collis-Curve TB		Radius TB		Denture TB		Waterpic

Tooth paste used? Amount / Type	☐ yes ☐ no
If no, moistened with:	Water ☐ yes ☐ no Mouthwash ☐ yes ☐ no Dry Brush ☐ yes ☐ no
Other Prescribed treatments applied? How?	Chlorhexidine or similar rinse or spray ☐ yes ☐ no Fluoride rinse or gel ☐ yes ☐ no
	Plaque Indicating Rinse ☐ yes ☐ no Oral lubricants ☐ yes ☐ no
	Other
Other AT used during oral care	Other

	Built-up Handle		Utensil Holder		Weighted Handle or Wrist Cuff		Weighted Items		Pressure Clothing		Timer
	Visual Activity Cues		Verbal Cueing Device		Neck Support		Flossing Aid		Mouth Prop		Tooth Paste Tube Squeezer

How often are teeth brushed/When?	☐ 1x/day ☐ 2x/day ☐ 3x/day Intermittent Oral Swabs or Tx?
How often are teeth flossed	Method/tools used:

How is individual positioned for oral-care	☐ In wheelchair ☐ In wheelchair, reclined/tilted approx. ______◦ ☐ In chair ☐ On toilet ☐ In commode chair ☐ In elevated sidelying ☐ Standing ☐ Other
How are staff/family positioned when assisting in oral-care	☐ To the side ☐ Behind ☐ In front Describe:
What support is used	☐ Hand on top of head ☐ Arm around neck and to the side of cheek ☐ Jaw/lip Control positions ☐ Retract lip/cheek with gloved finger ☐ Other
Head Position	☐ Neutral ☐ Chin-tuck ☐ Neck flexion/rotation used for excess saliva drainage ☐Other
Bruxism	☐ yes ☐ no
Xerostomia	☐ yes ☐ no
Excessive Drooling	☐ yes ☐ no
Can individual spit during oral care	☐ yes ☐ no
How is excess saliva removed	Suction ☐ yes ☐ no Positioning ☐ yes ☐ no Oral Swab ☐ yes ☐ no Other:
Sensory Considerations	☐ Resists tooth brushing to: ☐ Outer surfaces ☐ Biting Surfaces ☐ Inner surfaces ☐ Specific Areas Describe Quadrants: ☐ Gags ☐ Bites Toothbrush ☐ Needs frequent breaks Oral Cavity appears: ☐ hypersensitive ☐ hyposensitive ☐ Mixed sensitivity ☐ WFL Has a Sensory Support Plan ☐ yes ☐ no Comments:
Behavioral Considerations	☐ SIB ☐ Very Anxious ☐ Aggression ☐ Rumination ☐ Other Has a Behavioral Support Plan ☐ yes ☐ no Uses strategies such as: ☐ Environmental ☐ Music/Relaxation ☐ Breathing Activities ☐ Increased Choice/control ☐ Reinforcement Plan ☐ Positive Verbal Support ☐ Increase cognitive awareness of consequences of behavior ☐ Other
Dietary Considerations	☐ Sugar intake limited ☐ Uses dietary supplements ☐ Uses Thickening Products ☐ Able to rinse after supplements ☐ Able to rinse or clean oral cavity before bed ☐Other

General Oral Health	Other observations:									Comments
Missing Teeth		Yes		No	Cracked/Broken		Yes		No	GERD effects
Redness/Irritation		Yes		No	Bad Breath		Yes		No	Rumination effects
Bleeding gums		Yes		No	Sensitive to Temp		Yes		No	

IF NO CARMP IN PLACE: Is there a Nursing Oral Hygiene Plan *(Collaborate with Nursing as needed)*	☐ yes ☐ no Comments: *Are staff/family following current plan?*
Are there special Dentist Instructions *(Collaborate with Nursing/dental as needed)*	☐ yes ☐ no Comments:
Is oral care addressed in the Positioning Plan/ BSC Plan *(Collaborate with PT/BSC as needed)*	☐ yes ☐ no Comments: *Are staff/family following current plan?*

Comments /Tx Planning	