Occupational Therapy Feeding Assessment

Student: _____Date:_____

Self-feeding skills

Feeds self Y ❑ N ❑ Level of assistance:_____

Uses spoon Y ❑ N ❑

_____

Uses fork Y ❑ N ❑_____

Uses cup Y ❑ N ❑_____

Uses bottle Y ❑ N ❑_____

Finger foods Y ❑ N ❑

_____

Needs frequent cues when mouth is too full Y ❑ N ❑

Needs frequent cues to stay on task Y ❑ N ❑

Needs frequent cues for portion control Y ❑ N ❑

Needs frequent cues for bite size pieces of food Y ❑ N ❑

Needs assistance with set up Y ❑ N ❑

Needs assistance opening containers Y ❑ N ❑

Needs assistance cutting food Y ❑ N ❑

Hand Dominance: Right ❑ Left ❑

Sensory Issues:____Y_____N_____

Decreased head/trunk control:____Y_____N_____

Abnormal muscle tone:____Y_____N_____

Utensils and Equipment used:_____

Positioning during observation:_____

Comments:

_____

Occupational Therapist:

Email:

School: