**Speech Language Pathologist Feeding Assessment**

Student:_____Date:_____

Oral Motor

Head Control

Facial Tone

_____

Jaw

_____

Lips_____

Tongue _____

Lateralize L to R Y ❑ N ❑

Lateralize R to L Y ❑ N ❑

Tongue Thrust Y ❑ N ❑

Collect Bolus Y ❑ N ❑

Propel Bolus Y ❑ N ❑

Residual Food Y ❑ N ❑

Cough/Clear Throat Y ❑ N ❑

Dentition _____

Gag Reflex _____

Palate _____

Voice _____

Phonation _____

Other _

_____

Speech Therapist:_____

School:_____Email:_____