

## Eating Skills Screening

Student's Name \_\_\_\_\_

Date \_\_\_\_\_

Evaluators \_\_\_\_\_

School/class \_\_\_\_\_

<b>Positioning Screening</b>	
<i><b>Standard Positioning</b></i>	<i><b>Limiting Factors</b></i>
<p><i><b>Pelvis</b></i></p> <p><input type="checkbox"/> Pelvis neutral  <input type="checkbox"/> Pelvis against back of chair</p> <p><i><b>Trunk</b></i></p> <p><input type="checkbox"/> Trunk upright  <input type="checkbox"/> Trunk supported</p> <p><i><b>Legs</b></i></p> <p><input type="checkbox"/> Minimum of 90 degree hip and knee flexion for functional sitting  <input type="checkbox"/> Upper thigh support  <input type="checkbox"/> Ankles and feet supported by surface</p> <p><i><b>Shoulders</b></i></p> <p><input type="checkbox"/> Freedom of movement of shoulder girdle and scapula  <input type="checkbox"/> Upper back supported</p> <p><i><b>Head</b></i></p> <p><input type="checkbox"/> Head positioned at midline  <input type="checkbox"/> Chin tuck</p> <p><i><b>Arms</b></i></p> <p><input type="checkbox"/> Supported  <input type="checkbox"/> Freedom of movement</p>	<p><i><b>Pelvis</b></i></p> <p><input type="checkbox"/> Posterior Pelvic tilt                      <input type="checkbox"/> Anterior Pelvic tilt  <input type="checkbox"/> Pelvic Obliquity                              <input type="checkbox"/> Wind Swept deformity  <input type="checkbox"/> Decreased Range of mobility  <input type="checkbox"/> Any bracing or adaptive equipment/supports utilized? _____</p> <p><i><b>Trunk</b></i></p> <p><input type="checkbox"/> Scoliosis              <input type="checkbox"/> Fixed or              <input type="checkbox"/> Functional  <input type="checkbox"/> Low tone              <input type="checkbox"/> High tone  <input type="checkbox"/> Inadequate trunk rotation to achieve trunk symmetry  <input type="checkbox"/> Any bracing or adaptive equipment/supports utilized? _____</p> <p><i><b>Legs</b></i></p> <p><input type="checkbox"/> Hips positioned at less than 90 degrees of flexion/greater than 90 degrees of flexion  <input type="checkbox"/> Knees positioned at less than 90 degrees of flexion/greater than 90 degrees of flexion  <input type="checkbox"/> Leg length discrepancy  <input type="checkbox"/> Lack of support surface  <input type="checkbox"/> Any bracing or adaptive equipment/supports utilized? _____</p> <p><i><b>Shoulders</b></i></p> <p><input type="checkbox"/> Shoulders are elevated              <input type="checkbox"/> Shoulders are protracted              <input type="checkbox"/> Shoulders are retracted  Additional supports/adaptations utilized? _____</p> <p><i><b>Head</b></i></p> <p><input type="checkbox"/> Poor Head Control                      <input type="checkbox"/> Head tilt or rotation towards one side  <input type="checkbox"/> Inadequate head and neck rotation to bring head to midline  <input type="checkbox"/> Head is extended                      <input type="checkbox"/> Head is flexed</p> <p><i><b>Arms</b></i></p> <p><input type="checkbox"/> No supporting surface                      <input type="checkbox"/> Unable to bring to midline  <input type="checkbox"/> Low tone                                      <input type="checkbox"/> High Tone</p> <p><i><b>Reflexes</b></i></p> <p><input type="checkbox"/> ATNR    <input type="checkbox"/> STNR</p> <p><i><b>Movement Disorder</b></i></p> <p><input type="checkbox"/> Athetoid                      <input type="checkbox"/> Dystonia                      <input type="checkbox"/> Ataxia                      <input type="checkbox"/> Other _____</p>

## **Sensory and Communication**

### **Vision**

### **Hearing**

### **Environment**

- Student is able to sit and focus during mealtime
- If no, strategies required? \_\_\_\_\_

### **Communication**

- Student makes choices: How? (Language, eye contact, vocalizations, facial/body gestures)  
\_\_\_\_\_
- Student uses Adaptive Communication Devices: What kind?  
\_\_\_\_\_
- Student follows directions:  
Verbal                      Demonstration

## **Self Feeding Screening**

### **Arms and Hands**

- Student grasps utensil:  
Right hand      Left Hand
- Student uses adapted utensil
- If yes, what kind? \_\_\_\_\_
- Student can bring utensil to mouth:  
Independent      Needs Assistance
- Student holds cup:  
One hand grasp      Two hand grasp
- Student uses adapted cup
- If yes, what kind? \_\_\_\_\_
- Student spears food
- Student scoops food
- Student cuts food
- Student drinks from a straw
- Student opens containers (i.e. milk, juice)
- Student opens plastic packages (i.e. sporks, cookies)

<b>Oral Feeding Skills</b>		
<b><i>Normal Oral Patterns</i></b>	<b><i>Functional Skills</i></b>	<b><i>Limiting Oro-Motor Patterns</i></b>
<input type="checkbox"/> Jaw stability – opens and closes smoothly with appropriate amount <input type="checkbox"/> Tongue stability – stays in mouth, except to lick lips <input type="checkbox"/> Flattened, cup-shaped tongue <input type="checkbox"/> Tongue lateralizes for chewing <input type="checkbox"/> Lip closure <input type="checkbox"/> Movements are smooth and controlled	<b><i>Spoon Foods</i></b> <input type="checkbox"/> Flat tongue <input type="checkbox"/> Jaw and lips close smoothly to remove food <input type="checkbox"/> Tongue stays in mouth during swallow <input type="checkbox"/> Food completely swallowed <b><i>Liquids</i></b> <input type="checkbox"/> Jaw opens mid range and remains stable <input type="checkbox"/> Lower lip seals on cup <input type="checkbox"/> Upper lip contacts liquid <input type="checkbox"/> Jaw drops to pull liquid into mouth <input type="checkbox"/> Lips close <input type="checkbox"/> Tongue remains in mouth during swallow <input type="checkbox"/> Liquid completely swallowed <b><i>Chewables</i></b> Bites down when food is placed between: <input type="checkbox"/> Incisors <input type="checkbox"/> Molars <input type="checkbox"/> Repeated opening and closing of jaw to crush food <input type="checkbox"/> Lateralization of tongue to move food to molars <input type="checkbox"/> Lateralization of jaw to crush food <input type="checkbox"/> Food transferred to middle of tongue for swallow <input type="checkbox"/> Transfers food from one side to the other <input type="checkbox"/> Student manages tough or chewy foods	<b><i>Jaw</i></b> <input type="checkbox"/> Jaw thrusting: Jaw moves open suddenly, with force or an exaggerated up-down excursion <input type="checkbox"/> Tonic bite: Jaw moves upward into a tightly clenched posture when teeth are stimulated by finger, spoon, object. <input type="checkbox"/> Difficulty opening mouth. <b><i>Lips and Cheeks</i></b> <input type="checkbox"/> Lip retraction: If muscle tone is too high, tendency for the lips and cheeks to be pulled into a retracted position. <input type="checkbox"/> Limited upper lip movement: In high tone causes lips to be stiff. In low tone causes lips to be floppy or tight. <input type="checkbox"/> Low tone in cheeks <b><i>Tongue</i></b> <input type="checkbox"/> Exaggerated tongue protrusion: In-out movement of the tongue is exaggerated. <input type="checkbox"/> Tongue moves forward beyond the border of the gums and may stick out between the lips. <input type="checkbox"/> Tongue thrust: Forceful protrusion of the tongue from the mouth. May push food out of the mouth. <input type="checkbox"/> Bunched tongue