Saliva Control Assessment Form

Date: / / 
Name: 
Form completed by: 

1. **Communication skills:**
   - [ ] No problems
   - [ ] Some speech which is functional
   - [ ] Uses speech to get message across but with difficulty
   - [ ] Has difficulty making some sounds in words
   - [ ] Has no speech

2. **Walking**
   - [ ] No difficulty
   - [ ] Has some difficulty but walks independently without an aid
   - [ ] Needs a walking aid
   - [ ] Uses a wheelchair all or most of the time

3. **Head position**
   - [ ] Can hold head up without difficulty
   - [ ] Tends to sit with head down mostly

4. **Is the mouth always open?**
   - [ ] Yes
   - [ ] No
   - [ ] Unsure

5. **Lips**
   - [ ] Can hold lips together easily and for a long time
   - [ ] Can hold lips together with ease for a limited time
   - [ ] Can hold lips with effort for a limited time
   - [ ] Can bring lips together only briefly
   - [ ] Unable to bring lips together

6. **Can s/he pucker lips (as in a kiss)?**
   - [ ] Yes
   - [ ] No
   - [ ] Unsure

7. **Does s/he push the tongue out when swallows?**
   - [ ] Yes
   - [ ] No
   - [ ] Unsure
8. **Straw**
   - [ ] Can use a straw easily
   - [ ] Has difficulty using a straw
   - [ ] Cannot use a straw

9. **Eating/drinking**
   - [ ] Can eat whole hard foods that are difficult to chew
   - [ ] Eats a wide range of foods
   - [ ] Needs to have food cut into small pieces
   - [ ] Food needs to be mashed/pureed
   - [ ] Drinks need to be thickened
   - [ ] Has food through a tube (nasogastric / gastrostomy)

10. **Is s/he a messy eater?**
    - [ ] Yes
    - [ ] No
    - [ ] Unsure

11. **Can s/he swallow saliva when asked to?**
    - [ ] Yes
    - [ ] No
    - [ ] Attempts
    - [ ] Unsure

12. **Does s/he notice saliva on lips/chin (perhaps tries to wipe chin)?**
    - [ ] Yes
    - [ ] No
    - [ ] Unsure

13. **General health**
    - **Does s/he have asthma?**
      - [ ] Yes
      - [ ] No
      - [ ] Unsure
    - **Does s/he have frequently blocked or runny nose?**
      - [ ] Yes
      - [ ] No
      - [ ] Unsure
    - **Does s/he have bouts of pneumonia?**
      - [ ] Yes
      - [ ] No
      - [ ] Unsure

14. **Are there any difficulties with teeth cleaning?**
    - [ ] Yes
    - [ ] No
    - [ ] Unsure

15. **Has there been a recent dental check?**
    - [ ] Yes
    - [ ] No
    - [ ] Unsure
    IF YES, who?

16. **Are there any problems with bleeding gums or decayed teeth?**
    - [ ] Yes
    - [ ] No
    - [ ] Unsure

Thank you for completing this questionnaire.