

Quick Oral Exam (QOE)

Name:

Date:

Teacher/Parents/Caregiver:

Grade:

Age:

Birth Date:

Examiner:

I. External Observations

1. Front View; Lips and Jaw at Rest; Respiration
Lips Consistently: Occluded; Parted, # of mms separated _____; Inconsistent; both
Labial Tissue: Closes comfortably; Unable to close; Lower lip postures under top teeth
Lower Jaw: Elevated appropriately; Lowered (more than 3 mms); Clenched
 Symmetrical Jaw-Line; Asymmetrical Jaw-Line (jaw postures off to one side)
2. Front View; Facial Shape: _____
 Average; Narrow; Wide
3. Profile View; Top Jaw to Bottom Jaw Relationship
 Vertically Straight; Convex; retrognathic mandible; Concave; forward mandible (Class III)
4. Respiration: Nose Breathes; Mouth Breathes; Both: _____

2. Observations During Speaking

1. Intelligibility During Conversation: 100%; 90%; 80%; 60% or below
2. Jaw Vertical Movement During Speaking: Appropriate; Excessive/Large; Minimal/Small
3. Jaw Lateral Movement During Speaking: Normal; Chronically veers ___Left, ___Right, ___Both
4. Tongue Surface: Don't see frequently (appropriate); Frequently see the tongue surface when talking
5. Tongue's Plane of Movement: Normal front- and back-tongue vertical mvmt; Horizontal mvmt;
 Jaw-driven tongue movement (tongue initiates minimal movement)

Comments:

3. Dentition

1. Dental Development Stage: Primary (baby); Permanent; Mixed Dentition (aged 5–13)
2. Occlusion: Teeth occlude normally in front and back _____
Vertical Dimension: Openbite, ___Anterior, ___Unilateral, ___Bilateral; Overbite
Horizontal Dimension: Overjet; Underbite (Class III); Crossbite
3. Diastema (space): Between Top Incisors; Between Bottom Incisors; Multiple Diastemas

Comments:

4. Direct Intra-Oral Observations

1. Tongue Appearance: Size is commensurate with size of mouth; Too large; Too small
 "Still" when at rest; Noticeable fasciculations (twitches/spontaneous moves)
2. Pharynx: Able to see; Size, ___Normal, ___Large, ___Small; Unable to see _____
3. Tonsils: Tonsils have been removed; Has tonsils; Appearance: _____
 Average to small size; fit well within pharynx; allows adequate room for base of tongue
 Large tonsils: ___fills pharynx, ___commensurate with size of pharynx (large tonsils in large pharynx)
4. The Lingual Frenum: Normal Appearance; Short and restrictive _____
5. The Labial Frenums: Normal Appearance; Bulky and intrusive on dentition _____

Comments:

5. Observations/Interactions with Dental Arch & Palate

1. Dental Arch (upper): Normal, Adequate Width; Abnormally Narrow; Abnormally Wide
2. Palatal Vault: Average Height; Abnormally High; Tongue has Difficulty Accessing; Flat
 Size/Shape of the Arch/Vault is NOT Adequate to Consistently Accommodating Tongue Interaction
3. Alveolar Ridge: Nicely rounded; Abnormally pointed; Rugae is ___bumpy, ___smooth
4. Palatal Appliance: No; Yes: ___palatal expander, ___reminder device (for tongue/digit)
 Has worn one in the Past; Dentist/Ortho plans to insert one in the Future
5. Lingual Interaction: Able to reach the palate to do a Tongue Pop; NOT Able to do Tongue Pop; Tongue
Resting Posture: ___on Top, ___at Midline, ___Low and forward, ___Off to one side

Comments:

Impressions; Areas to Investigate Further

Examiner

Date

The Quick Oral Mech Exam

Instructions

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The mouth is the source of speech and we can't ignore it. In my therapy I want to know the condition of the mouth I'm working with so I can adjust my therapy to the needs of the child.

Realistically, we don't have tons of time. An in-depth investigation is ideal, but there are times when quick has to suffice. Following is a 5-phase bottom-line oral mechanism analysis that takes 2 to 3 minutes to do. It contains procedures and rationale.

Also, keep in mind that, from my perspective, an oral-facial exam is most beneficial when associated with speech function and the oral resting position. As you know, the oral resting position determines the tongue's speech operating zone as it interacts during speaking. An ideal oral rest posture maximizes the tongue's ability to *stabilize* during speech movements, and *mobilize* and interact with the alveolar ridge, hard palate, etc. during productions.



1. While You are Talking to the Child

During your initial conversation with the child, i.e. being friendly, putting the child at ease, analyze the child's face, lips, and jaw from the front and side views. Do this informally as the child listens. Once you know what you're looking for this just take a few seconds.

Front View: Notice Lips and Perhaps, the Tongue

- **Are the lips comfortably closed** when the child is not talking? If not, **are they parted?** Just slightly parted, or are the lips apart because the jaw is lowered? Do they look like they would close if the jaw was elevated? Are they closed/parted consistently or inconsistently?
- Does **the lower lip** slide under the top, front teeth at rest? This would indicate a dental overjet.
- If his lips are apart, **do you see the tongue?** Is it down, or down and forward? If it's down, the child is probably breathing through his mouth. If it's down and forward, he's probably blocking his oral airway and he's breathing through his nose.
- If **the lips are parted, why?** Make a note to go back later and check to see if the child can achieve nasal airflow, or not. Try to track down why.

Front View: Notice Facial Shape

- **The structure of the cranio-facial bone is the bony framework of the mouth.** Making note of external characteristics will guide your investigation once you're inside the mouth.
- **A narrow face** may indicate a narrow dental arch. **A wide face** may indicate an excessively wide dental arch. Both of these extremes may make tongue-palate resting and speech sound production effortful. Note the word "may;" some individuals are able to compensate, others aren't.
- Note **jaw symmetry**. Does the lower jaw jut off to one side or forward?
- **If the child produces "frontals"** it's not unusual to see a longer face with chronically parted lips. And, when lips are open, the tongue is down, probably at the horizontal midline. (Conversely, it is ideal for the tongue to rest on top so it can easily access speech sound stabilization and mobilizations.)

Profile View: Notice the Vertical Symmetry of the Top-Jaw to the Bottom-Jaw

You may have to be a little sneaky to see his facial profile. Either stand up and "get something" and check-out his profile or, ask him to turn to the side in the pretext of admiring his hair.

- The ideal profile is when the jaws are **straight vertically and in proportion to one another**.
- Keep in mind that **wherever the jaw goes, so goes the tongue**. If the jaw is either forward or retracted (in relation to the dental arch and palate) the tongue may have difficulty accessing and interacting for speech. There may be frontal productions or general lack of clarity due to lingual contact-imprecision with the alveolar ridge and palate.
- In other words, if the mandible is significantly protruded or retruded, the tongue may or **may not be able to correctly interact** (rest, stabilize and mobilize) with the roof of the mouth.

2. While the Child is Talking to You

The following observations and the items in Phase #1 guide you as you as you move closer to looking inside the child's mouth.

Continuing your informal conversation and observations, observe the child's mouth while he is talking. What do you see?

- Watch **the child's jaw** as he speaks. Do you see excessive jaw movements either vertically or horizontally or, does the child try to speak with his jaw elevated?
- Do you frequently see **the surface of a child's tongue as he speaks**? It is not normal to chronically see the surface of the tongue when speaking. Ideally the tongue interacts up within the dental arch, with the tongue-sides on the side teeth to one degree or another. A very visible tongue-surface may indicate a tongue that is operating on the horizontal plane (it moves anteriorly-posteriorly) rather than vertically.
- Determine the **tongue's primary movement plane**. Does the whole tongue move horizontally? Or do you see front-tongue vertical movements? Consonant speech sounds are made with front- and back-tongue vertical movements. It means that he is able to successfully move the front part of his tongue.

3. Analyze Teeth

For kids not excited to have you looking inside their mouth, especially if you have a tongue depressor in hand, I recommend starting with innocuous dental analysis. A couple things to know as you analyze their teeth.

- Vertically, the top front teeth overlap the bottom front teeth within the top third of the bottom teeth.
- Horizontally, it is normal for the top front teeth to be "out" from the bottom front teeth 1 to 3 mms.
- Also, children go through mixed dentition between the ages of 5 to 13 or so.

Ask the child to bite his teeth together and smile. Make sure his lips are out of the way so you can see his teeth.

- Note the **stage of dental development**. Is he in the deciduous phase (all baby teeth), or has he moved into the mixed dentition phase? If he's a middle- or high-school student he may have all of his adult teeth.
- Note the **condition of his teeth**. Is his occlusion good, or does he have a dental malocclusion, such as, an openbite (vertical space in front or on the sides), or an overbite (too much front-teeth overlap), or an overjet (horizontal protrusion), or underbite (Class III)? Look at quadrants of teeth, not just individual teeth to determine a malocclusion. Keep in mind that teeth don't typically move "out of position" on their own. There's usually a reason, e.g., thumb, finger, pacifier, tongue, etc.
- **Compare what you learned** from analyzing the jaw-to-jaw profile relationship. Are the characteristics you saw on the "outside" reflected on the "inside"? If there is a significant difference between the jaws (externally) and the teeth (internally), determine why. For example, if the external jaw-to-jaw profile looks straight, but inside, the lower teeth are tipped forward (as in an underbite), chances are the tongue has been chronically pushing against the lower, front teeth. This lets you know that the tongue chronically moves horizontally. In all probability, he has a frontal speech pattern. (Basically, connect the dots.)
- Is the child wearing **orthodontic braces**?

4. Investigate Inside

Compliment the child on his nice teeth and ask him if he has a tongue. Usually, they open right up. If not, ask him to open. If he doesn't, let him take a look in your mouth; then "compare." You'll need a penlight and tongue depressor, and it helps (but it's optional) if you have flavored spray. Try "Too Tarts Flavored Spray" at Amazon.

Look at his tongue:

- Determine if the **size of his tongue is commensurate with the size of his mouth**. (This is obviously subjective but is easily recognizable when there's a big difference; the tongue fills the oral cavity.)
- Place a tongue depressor on the front-to-mid surface of his tongue to see if he accepts the sensory input. If he not, you'll probably get a gag response. Look quickly at the pharynx to see if there are tonsils. If he is accepting of the tongue depressor, continue to the back and apply moderate pressure on the back of the tongue to get a **view of his pharynx**. Simultaneously ask him to say "ah." Determine if he has tonsils or not and look at the size of his pharynx. **Your goal is to determine if there is space for the base of the tongue to rest and function within the pharyngeal area**. While you're back there have him say "ah" again and make note of soft palate vertical movement.
- Next **look underneath the tongue**. Make a note of the lingual frenum, e.g. where it's attached (mid-tongue or toward the tongue tip), and its vertical length. We'll come back to the lingual frenum in Phase #5. The most effective way of analyzing the lingual frenum is through tongue-palate contact.
- A less common occurrence are **restrictive labial frenums**. If you noticed that he has a significant space between his front teeth (typically the top) it may be due to a short labial frenum. Directly check the frenum by lifting (or lowering) the lip with your tongue depressor to view the frenum.

5. Observe and Interact with the Dental Arch and Palate

- First, eyeball the width of the **upper dental arch**, as well as the **width and height of the hard palate**. Without the benefit of tongue interaction, it's subjective. Extremely narrow or extremely wide is obvious. Either of these may pose lingual stabilization difficulty (see Therapy Matters #7 on Tongue Bracing).
- Make note of the **appearance of the alveolar ridge and the hard palate**. A younger child will have a bumpy alveolar ridge and an older child or teen should have a smooth alveolar ridge. The more years the tongue has rested and interacted on top, the smoother the alveolar ridge. In addition, sometimes the alveolar ridge is "pointed." This unusual shape makes it tough for tongue interaction.
- Are there **appliances** up within the dental arch and palatal vault? If there is a **palatal expander**, make note of the type and ask the child how long it's been in. Is there a thumb/finger/tongue **reminder appliance**? These are usually positioned below the alveolar ridge and/or palate to "block" the offender.

Next, and most importantly, look at the tongue's interaction with the roof of the mouth. These tasks give you the fundamental info you need about the child's ability to rest his tongue on top, and to ultimately achieve appropriate stabilization and mobilization for speech sound productions.

- Ask the child to do a **tongue pop**. Does the tongue easily **lift and fit up into the roof of the mouth**? If so, all systems are go.
- Is his tongue able to elevate up to the top or **does the anterior portion fold back in an effort to make palatal contact**? If so, this is a **red flag** indicating that tongue-palatal positioning is not familiar. His tongue, therefore, probably rests and functions "down" at midline.
- If the tongue is unable to reach the top, it may be tethered by a restrictive lingual frenum. Check the **tongue's "reach-ability."**
- If the palatal distance is too great for the tongue (for whatever reason), ask the child to **bite on a child-sized tongue depressor** with his back teeth and do a tongue pop as best he can. The small tongue depressor **keeps the jaw closed and centered and the tongue in close proximity to the roof of the mouth**. Chances are, if the tongue is able to reach and fit, it will. If not, it won't.