

# ORAL-MOTOR, FEEDING & SPEECH HOMEWORK CHART

Name: \_\_\_\_\_

Date of Therapy: \_\_\_\_\_

Exercise to be Completed	Number of repetitions*	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
<b>Sensory</b>								
<b>Feeding</b>								
<b>Oral-Motor Activities</b>								
<b>Speech</b>								
<b>Other</b>								