Please describe the swallowing problem: ______________________________________________________

Onset of swallowing problem: □ gradual □ sudden □ past few weeks □ past few months □ 6 – 12 months
□ over ___years
Has the problem changed over time? □ Improved □ Gotten worse □ Same
Have you received previous swallowing evaluations and/or treatment? □ NO □ YES
If yes, list dates, name, location and phone number: __________________________________________

Please describe the consistency of foods and liquids you are currently eating:
□ Regular foods   □ Cut up or soft foods   □ Finely chopped   □ Puree
□ Thin liquids   □ Nectar thick liquids   □ Honey thick liquids
□ Other________________________

Do you have a feeding tube? □ No □ Yes (date placed): ________________________________
Amount/type of feeding per day: _______________________________________________________
How do you take Medication? _______________________________________________________

Have you had a recent weight loss? □ No □ Yes ___# of lbs. over ___ weeks/mos.
Describe your appetite: □ Good □ Fair □ Poor

Do you have dietary restrictions or have you eliminated any foods from your diet?
□ No □ Yes (Please state restrictions) _________________________________________________
Food Allergies □ No □ Yes __________________________

Please describe any management strategies you are using to swallow your current diet: __________________________

Length of meal time: □ < 20 minutes □ 20 - 30 minutes □ > 30 minutes
Do you require any assistance with your meals? □ NO □ YES (describe) ______________________

Do you wear dentures? □ No □ Yes Circle: Upper / Lower / Partial
What is your current physical status? □ Walk □ Cane □ Wheelchair
Can you support your upper body? □ No □ Yes □ Head? □ No □ Yes
Please describe your voice: □ Normal □ Hoarse □ Breathy □ Weak □ No voice
Do you experience any of the following? (Check all that apply)
□ Poor morning voice quality □ Throat soreness or burning sensation not related to illness
□ Frequent throat clearing □ Coughing episodes not related to illness/swallowing
□ Increased phlegm in the throat □ Heartburn (If checked, how many times per week? _____)
□ Tastes repeating after meals □ Feeling of a lump in the throat when swallowing
□ Increased throat/mouth dryness □ Bad taste in the mouth (sour, acidic, metallic)
□ Frequent burping □ Unpredictable/variable voice quality during the day
□ Feeling of throat tightness □ Increased coughing when lying down
Do you take any medication for reflux? □ No □ Yes

Please write down any additional information you feel will help us understand your swallowing problem:

Speech Pathologist’s Notes: _____________________________________________________________