Swallowing Institute Case History

Name:		**Date:**
Occupation:		**Full-time or Part-time:**
Referring MD:		
ENT:	**Neurologist:**	
Primary Physician:	**Gastroenterologist:**	**Pulmonologist:**
Medical History:		
Surgery History:		
Hospitalizations:		
Describe your speech, voice, or swallowing problem in one sentence or less:		
What is your goal of speech therapy? **Have you had speech therapy before?** **When?** **Where?**		

Swallowing:

To what extent are the following scenarios problematic for you?	**0 = No problem**					**5 = Severe Problem**
1. My swallowing problem has caused me to lose weight	**0**	**1**	**2**	**3**	**4**	**5**
2. My swallowing problem interferes with my ability to go out for meals	**0**	**1**	**2**	**3**	**4**	**5**
3. My swallowing problem interferes with my work or other activities	**0**	**1**	**2**	**3**	**4**	**5**
4. Swallowing liquids takes extra effort	**0**	**1**	**2**	**3**	**4**	**5**
5. Swallowing solids takes extra effort	**0**	**1**	**2**	**3**	**4**	**5**
6. Swallowing pills take extra effort	**0**	**1**	**2**	**3**	**4**	**5**

To what extent are the following scenarios problematic for you?	0 = No problem 5 = Severe Problem					
7. I have altered my diet because of my swallowing problem	0	1	2	3	4	5
8. Swallowing is painful	0	1	2	3	4	5
9. The pleasure of eating is affected by my swallowing	0	1	2	3	4	5
10. When I swallow food sticks in my throat	0	1	2	3	4	5
11. When I swallow food sticks in my chest	0	1	2	3	4	5
12. I cough when I eat	0	1	2	3	4	5
13. I am afraid to eat because of my swallowing problem	0	1	2	3	4	5
14. My swallowing problem is a burden to my family	0	1	2	3	4	5
15. I get tired when I eat	0	1	2	3	4	5
16. I avoid eating in front of people	0	1	2	3	4	5
17. I am afraid of choking in my sleep	0	1	2	3	4	5
18. I become short of breath when I eat	0	1	2	3	4	5
19. People perceive me as sick because of my swallowing problems	0	1	2	3	4	5
20. Swallowing is stressful	0	1	2	3	4	5

1. Have you ever had pneumonia? When? _____
2. Do you eat regular food? _____ if not what diet? _____
3. When you eat or drink, do you have episodes of coughing? ☐ Yes ☐ No
4. When you eat or drink, do you have episodes of choking? ☐ Yes ☐ No
5. Do you wear dentures when you eat? ☐ Yes ☐ No
6. Does food or drink ever "go down the wrong way"? ☐ Yes ☐ No
7. Does your food generally require special preparation before you can eat it? ☐ Yes ☐ No

   If so, please describe: _____
8. Do you avoid certain foods because they are difficult to swallow? ☐ Yes ☐ No

   If so, please list examples: _____
9. Do you find food in your mouth after you swallow? ☐ Yes ☐ No
10. Do you have difficulty keeping food or drink in your mouth? ☐ Yes ☐ No
11. Do liquids ever come back through your nose when you swallow them? ☐ Yes ☐ No
12. Do you ever feel that food gets "stuck" in your throat? ☐ Yes ☐ No

    If so, describe where it feels stuck: _____
13. Do you regularly wake up at night coughing? ☐ Yes ☐ No

14. Do you often wake up with a bad/sour taste in your mouth? ☐ Yes ☐ No

15. Is your swallowing problem intermittent / constant? (Check one)

16. Has your swallowing problem changed over time? ☐ Yes ☐ No

    If so, please describe:__ _____

17. Are there any factors that make your swallowing problem worse? ☐ Yes ☐ No

    If so, please describe:__ _____

18. Has your voice changed in the past year? ☐ Yes ☐ No

    ☐ hoarse ☐ quieter

    ☐ whispery/breathy ☐ other _____

19. Did the changes in your voice start gradually / suddenly ? (Check one)

20. What was the date of onset of your voice change? _____

21. Has your speech changed in the past year? ☐ Yes ☐ No

    If so, check all that apply:

    ❑ slurring ❑ need to clear your throat more ❑ talking through your nose ❑ other _____

22. Did the changes in your speech start gradually / suddenly ? (Check one)

23. What was the date of onset of your speech change? _____

24. Have you had any previous swallowing or throat problems? ☐ Yes ☐ No

    If so, please describe:__ _____