

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?			
<i>Swallowing:</i>							
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					
	0	1	2	3	4	5
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

- Have you ever had pneumonia? When? _____
- Do you eat regular food? _____ if not what diet? _____
- When you eat or drink, do you have episodes of coughing? Yes No
- When you eat or drink, do you have episodes of choking? Yes No
- Do you wear dentures when you eat? Yes No
- Does food or drink ever “go down the wrong way”? Yes No
- Does your food generally require special preparation before you can eat it? Yes No
If so, please describe: _____
- Do you avoid certain foods because they are difficult to swallow? Yes No
If so, please list examples: _____
- Do you find food in your mouth after you swallow? Yes No
- Do you have difficulty keeping food or drink in your mouth? Yes No
- Do liquids ever come back through your nose when you swallow them? Yes No
- Do you ever feel that food gets “stuck” in your throat? Yes No
If so, describe where it feels stuck: _____
- 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: _____