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ADULT SPEECH-LANGUAGE PATHOLOGY SWALLOWING CASE HISTORY ATTACHMENT

Name: ________________________
Date of Birth: __________________

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 think 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 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: ☐ <20minutes ☐ 20-30minutes ☐ >30minutes

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
☐ Frequent throat clearing
☐ Increased phlegm in the throat
☐ Tastes repeating after meals
☐ Increased throat/mouth dryness
☐ Frequent burping
☐ Feeling of throat tightness
☐ Throat soreness or burning sensation not related to illness
☐ Coughing episodes not related to illness/swallowing
☐ Heartburn (If checked, how many timer per week? ____)
☐ Feeling of a lump in the throat after swallowing
☐ Bad taste in mouth (sour, acidic, metallic)
☐ Unpredictable/variable voice quality during the day
☐ 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:____
____