Stony Brook Medicine

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 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:_____
_____