Swallowing and Neurological Rehabilitation, LLC

Swallowing Screening

Name: _____ Date of Screening:_____
Date of Birth:_____ Phone Number: _____
Physician:_____ Current Diet: _____
Have you previously received speech therapy services? Y/N If yes, when? _____
Medical Diagnoses/Conditions:_____
Concern(s):_____

Questionnaire:

1. Have you noticed problems swallowing foods, liquids, or both? _____
2. Have you lost weight recently? **Y/ N**
3. Are you experiencing indigestion or burning near your sternum? **Y/ N**
4. Do you cough or choke while eating/drinking? **Y/ N**
5. Do you have problems swallowing pills? **Y/ N**
6. Do you get a runny nose after eating/drinking? **Y/ N**
7. Does food or liquid come back out of your nose after eating/drinking? **Y/N**
8. Do you feel a "lump" in your throat when you swallow? **Y/ N**
9. Do you experience pain when you swallow? **Y/N**
10. Do you experience an acidic or metallic taste in your mouth upon waking? **Y /N**
11. Do you notice a wet or gurgly voice after eating/drinking? **Y /N**
12. Do you have trouble chewing your food? **Y/N**
13. Does it take you a long time to eat? **Y/ N**
14. Do you experience increased phlegm or mucus after swallowing? **Y/ N**
15. Do you clear your throat after eating/drinking? **Y/N**
16. Do you find food stuck in your mouth after eating? **Y /N**
17. Do you experience dry mouth? **Y/ N**
18. Do the swallowing problems occur more during a specific meal? **Y/N** If yes, which meal? _____
19. When do the swallowing problems occur? (Check all that apply.)
    ( ) During eating ( ) After eating ( ) During drinking ( ) After drinking
20. How often do the swallowing problems occur?
    ( ) Occasionally ( ) Frequently ( ) Daily ( ) Every meal
21. What time of day do the swallowing problems occur most frequently?
    ( ) Morning ( ) Afternoon ( ) Evening ( ) No correlation with time of day
22. How long have you had this problem? **( ) Days ( ) Weeks ( ) Months ( ) Years**
23. Did the problem occur gradually or suddenly? **( ) Gradually ( ) Suddenly**
24. Which of the following describes your teeth? (Check all that apply.)
    ( ) Natural ( ) Some teeth missing ( ) Partials ( ) Upper dentures ( ) Lower dentures
25. Are some foods easier to swallow? **Y/N** If so, what foods?
    _____
26. Are some foods more difficult to swallow? **Y/N** If so, what foods?
    _____
27. Are you on any special diet currently? **Y/N** If so, please describe.
    _____
    _____