HILL COUNTRY DYSPHAGIA DIAGNOSTICS

A MOBILE FEES COMPANY

MOBILE FEES CLIENT INTAKE FORM

Client's Name: _____ DOB: _____

Name of person filling out form: _____ Contact #: _____

Pertinent diagnosis/Past Medical History:

_____

_____

_____

_____

_____

Brief Description of Swallowing Impairment:

_____

_____

_____

_____

Current Diet: _____

Has patient had a previous MBSS/FEES? **Y** **N**

Results/Comments: _____

Please fill out and email to hcddfees@gmail.com prior to exam.