CONNECT
speech language & swallowing services

SPEECH-LANGUAGE PATHOLOGY
ADULT SWALLOWING CASE HISTORY FORM

Date	Age

I. IDENTIFYING INFORMATION

Name: _____Date of Birth: _____
Mailing Address: _____
E-Mail: _____
Phone: _____ Phone 2:_____
Family physician: _____ Location/Phone: _____
Referral Source: _____

II. SOCIAL HISTORY

Languages spoken: _____
Marital status: _____ # Children: ___ Ages of children: _____
Does anyone else live with you? Spouse____ Children _____ Parents____ Grandparents____
Friends____ Other_____ (Circle whoever is your primary support)
Highest education Level: _____ Occupation: _____ Years: _____
Living Arrangements: □ House □ Apartment □ Independent Living Facility □ Assisted Living Facility □ Skilled Nursing Facility
Assistance needed: □ Caregiver □ No caregiver

III. PRESENT CONCERN

Please describe the swallowing or eating problem: _____
_____
How does the swallowing problem affect your life? _____
_____

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
How frequently does it occur? Circle: Daily/Weekly/Monthly/A few times a year.

Please describe any management strategies you are using to help you swallow your current diet:
_____

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Have you had any recent Chest X-Rays? □No □ Yes
Date: _____ Results: _____

Have you had a modified barium swallow test (MBS, VFSS) with an SLP in a radiology suite? □No □ Yes
Date: _____ Results: _____

Have you had a flexible endoscopic evaluation of swallow (FEES) with a tube inserted in nose? □No □ Yes
Date: _____ Results: _____

Have you received previous swallowing treatment with an SLP? □No □ Yes
If yes, list details (dates, name/title, location, duration):_____
_____

Check the problems you are currently experiencing: (If a choice is provided, circle the answer.)
□ Drooling during non-mealtimes
□ Losing food or liquid or both from your mouth during meals
□ Difficulty drinking with a straw
□ Difficulty chewing
□ Difficulty moving food or liquid or both out of the mouth and into the throat
□ Difficulty getting the swallow started
□ Pain during eating or swallow
□ Food or liquid or both coming out of the nose
□ Coughing or choking with food or liquid or both
□ Frequent throat clearing or coughing or both after the swallow
□ Sneezing during meals
□ Eyes watering during meals
□ Nose running during meals
□ Sensation of a lump or food sticking in the throat or chest. Specify where: _____
□ Difficulty swallowing pills
□ Needing to avoid certain food or liquid or both
□ Regurgitation or being unable to keep food or liquid or both down
□ Frequent burping during meals, after or both
□ Heartburn (If yes, how many times per week? ____)
□ Tastes repeating after meals
□ Coughing or choking on saliva not related to illness/mealtimes
□ Foreign body sensation in throat
□ Sudden coughing after lying down
□ Waking at night coughing or choking
□ Poor morning voice quality
□ Unpredictable/variable voice quality during the day
□ Thickened/excess mucus/phlegm or secretions in throat
□ Ulcers or sores in mouth
□ Throat soreness or burning sensation not related to illness
□ Bad taste in the mouth (sour, acidic, metallic)
□ Feeling of throat tightness
□ Dry mouth
□ Decreased mouth/jaw opening
□ Other _____

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IV. RELEVANT MEDICAL HISTORY

What is your general health and well-being status: exceptional average below average unhealthy
What is your current physical status? □ Walk □ Cane □ Wheelchair
Can you support: Your upper body? □No □ Yes Your head? □ No □Yes
□ Reflux/GERD/LPRD Current reflux medication and dosage/frequency: _____
□ Esophageal disorders: Explain: _____
□ History of aspiration
□ Infection or irritation, including pneumonia: Explain: _____Date:_____
□ Neurological deficits (e.g. stroke, concussion/brain injury, Parkinson, dementia, etc.): Explain/dates:
_____
□ Cardiac problems/disorders: Explain: _____
□ Pulmonary/Respiratory disorders: Explain: _____
□ Head and Neck Cancer: Location/type and date of diagnosis: _____
Do you have an active, untreated lesion in your head or neck? □No □ Yes
Surgery and dates: _____
Chemotherapy/Radiation (Circle) Current/Completed (Circle) Date of completion:_____
or # of treatments to date:_____
□ History of Voice Problems: Explain:_____
Please describe your voice presently: □Normal □ Hoarse □Breathy □Weak □ No voice

V. OTHER MEDICAL HISTORY

Please circle if more than one option provided:

□ Arthritis
□ Asthma (adult/childhood onset)
□ Bronchitis
□ Blood Sugar (high/low)
□ Diabetes (adult/childhood onset)
□ Headaches, migraines
□ High Blood Pressure
□ Kidney/Bladder Disease
□ Liver Disease
□ Joint/Bone Disease
□ Cancer (other than head and neck)
□ Tuberculosis
□ Thyroid disease
□ Bleeding Problems
□ Endocrine Disorder
□ GI Disorders (hernia, ulcers, colitis, etc.)
□ Sinus Disease
□ Peripheral neuropathy
□ Deep Brain Stimulation implants
□ Pacemaker
□ Internal cardiac defibrillator Other:
_____
□ Mental health disorder
_____

Please list any injuries/accidents and their approximate dates.
_____
Please list any surgeries (other than head/neck cancer) and their approximate dates.
_____
Current Medications including over-the-counter and herbal: _____
_____
Do you have allergies to drugs? environmental?_____
_____
Dentition/Teeth: □ Natural □ Upper/lower/partial Dentures □ No teeth □ Partial/Bridges □ Missing teeth
Current weight: _____ lbs. □ Recent Weight Loss: ___ #lbs. over _____ #weeks/months

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Are you currently taking antihistamines?_____If yes, list type and dosage._____
Are you currently using tobacco products? _____ If yes, list type _____
How much (packs/cans/etc.) per day?_____ For how long? _____
Have you used tobacco products in the past?_____ If yes, list type_____
How much (packs/cans/etc.) per day?_____ For how long?_____ Date of cessation_____
Are you exposed to secondhand smoke? □No □ Yes Explain:_____
Are you in contact with dust, fumes, chemicals or paints? □No □ Yes
Do you use products containing menthol?_____ If yes, please explain_____
Do you take Vitamin C supplements?_____ If yes, please list amount (mg) per day_____
Do you use recreational drugs?_____ If yes, please list type/amount/frequency_____

VI. CURRENT DIET

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?_____
Describe your appetite: □Good □ Fair □ Poor
Foods avoided because of your swallowing difficulties? _____
Do you have dietary restrictions or have you eliminated any foods from your diet? □No □ Yes
Please list: _____
Food Allergies □No □ Yes: _____
How much of your daily intake do you eat by mouth? All More than Half Less than Half None
How much of your daily intake goes into a feeding tube? All More than Half Less than Half None
Do you frequently use a straw with liquids? □No □ Yes
Does it take you longer to eat a meal than others? □No □ Yes
Length of meal time: □ < 20 minutes □20 - 30 minutes □> 30 minutes
Do you require any assistance with your meals? □No □ Yes Describe:_____
When do you have difficulty at mealtimes? Circle: Beginning/middle/end/ entire meal.

VII. HYDRATION

How much of the following do you drink per day? (1 cup/glass = 8 ounces)
How many ounces of water do you drink per day? _____
How many ounces of the following caffeinated beverages do you consume per day?
Coffee_____ Tea_____ Soda_____ Energy drinks _____ Chocolate_____
How often do you drink alcoholic beverages (daily, weekly, monthly, rarely, never, etc.)? _____
Amount in ounces: Beer_____ Wine _____ Liquor _____
How many ounces of the following beverages do you drink per day? Milk _____ Juice_____ Sports drinks _____ Other (please specify) _____

VIII: OTHER

Explain your goals regarding swallowing: _____
List any follow-up appointments scheduled with your referring physician: _____
Any additional information you feel will help us understand your swallowing problem?
_____
List assessment expectations or questions: _____