Intake Form

Patient Name:_________________ Patient Age________
Patient DOB_______________ Patient Sex_______
Facility Name_________________________

Medical History:

☐ CVA                    ☐ Parkinson’s Disease  ☐ Odynophagia
☐ Dementia               ☐ ALS                      ☐ Myasthenia Gravis
☐ HTN                    ☐ CAD                      ☐ Multiple Sclerosis
☐ COPD                   ☐ DM II                    ☐ Huntington’s Disease
☐ GI History             ☐ Dysphonia (vocal cord paralysis)
☐ Hiatal Hernia          ☐ Cancer History___________ ☐ Surgical History______

Admitting Diagnosis to Facility:
- 
- 
- 
- 
- 
- 
- 
- 
- 

Dysphagia History:

Aspiration:   ☐ Yes   ☐ No

Current Diet:________________________

Oral Motor Function:

☐ Poor Dentition   ☐ Edentulous   ☐ Partials   ☐ Dentures