OUTPATIENT SWALLOWING QUESTIONNAIRE
Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

General Information
What are your complaints regarding your swallowing?

____________________________________________________________
____________________________________________________________

Date of onset of swallowing problems ____________________________________

Check the problems you are currently experiencing:

□ Difficulty drinking with a straw
☐ Difficulty chewing food
☐ Difficulty getting the swallow started
☐ Pain during swallow
☐ Coughing or choking with food or liquid or both
☐ Frequent throat clearing or coughing or both after the swallow
☐ Sensation of food sticking in the throat or chest
Where specifically? __________________________
☐ Difficulty swallowing pills
☐ Needing to avoid certain food or liquid or both
☐ Regurgitation or being unable to keep food or liquid or both down

☐ Coughing or choking on saliva during non-mealtimes
☐ Sudden coughing after lying down
☐ Burping during or after meals
☐ Waking at night coughing or choking
☐ Waking with a sour taste in mouth
☐ Hoarseness or a problem with your voice
☐ Clearing your throat
☐ Excess mucous or post nasal drip
☐ Sensation of something sticking in your throat or a lump in your throat
☐ Heartburn, chest pain, indigestion, or stomach acid coming up

(Pg. 1 of 2)
Current diet:
- Solids: □ regular □ soft □ mechanical soft □ pureed
- Liquids: □ thin □ nectar-thick □ honey-thick □ nothing by mouth

Do you avoid certain foods because of your swallowing difficulty? □ yes □ no
If yes, what foods do you avoid? ____________________________________________

When do you have difficulty at mealtimes? □ beginning □ middle □ end □ throughout

How frequently do you have trouble? □ all the time □ sometimes □ occasionally

Have you had previous therapy for swallowing? □ yes □ no
If yes, please explain _______________________________________________________

Pertinent Medical History
Please check all that apply.
□ Reflux/GERD
   Do you take medication? □ yes □ no
   If yes, please list _________________________________________________________

□ Esophageal disorders (i.e., stretching of the throat, hiatal hernia, Barrett’s esophagus) Please explain _____________________________________________________________

□ History of aspiration

□ Recurrent pneumonia

□ Neurological deficits
   Please explain _____________________________________________________________

□ Respiratory disorders
   Please explain _____________________________________________________________

□ Head and neck cancer
   Please explain _____________________________________________________________

To the best of my knowledge the above information is complete and factual.

__________________________________________  _________________________________
Patient Signature                        Date/Time