Voice and Swallow Clinics

Medical Intake Form for **Swallow (Revisit)** Patients

Date: _____

MRN (Staff Input) _____

Name: _____

Date of birth: _____

1. Current swallowing concerns/symptoms

› Has your swallowing changed since your initial evaluation? ☐ Yes ☐ No
If yes, please describe:

› If you answered yes, are there any events or circumstances that you associate with the improvement or deterioration in your swallowing since the initial evaluation?

Event	Has made my swallow			
Swallowing therapy	☐ Better	☐ No change	☐ Worse	☐ Not applicable
Change of diet	☐ Better	☐ No change	☐ Worse	☐ Not applicable
Change in medication	☐ Better	☐ No change	☐ Worse	☐ Not applicable
Surgery	☐ Better	☐ No change	☐ Worse	☐ Not applicable
Other: _____	☐ Better	☐ No change	☐ Worse	☐ Not applicable

2. Are you having symptoms of swallowing difficulties? ☐ Yes ☐ No (if no, please skip to section #4)

3. Since your last visit, describe the nature of your swallowing function:

› Your swallowing is: ☐ Normal ☐ A little difficult ☐ Somewhat difficult ☐ Very difficult

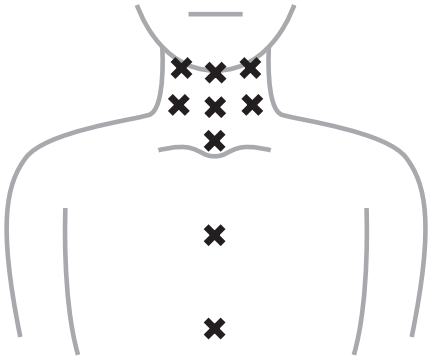
› Do you ever feel that food, liquid or pills get stuck? ☐ Yes ☐ No ☐ Occasionally

› Where do you feel food or liquid gets stuck? (circle "x" where food, liquid or pills get stuck)

› If other places, please describe:

_____

_____



› Do you avoid certain SOLID foods because of difficulties swallowing them? ☐ Yes ☐ No ☐ Occasionally

› Do you avoid certain LIQUIDS because of difficulties swallowing them? ☐ Yes ☐ No ☐ Occasionally

If yes to above questions, please describe _____

› Since your last visit, do you have pain upon swallowing? ☐ Yes ☐ No ☐ Occasionally

› Are there things you have stopped doing because of your swallowing problems? ☐ Yes ☐ No ☐ Occasionally

If yes, please list _____

› Have you had any choking episodes warranting the Heimlich maneuver? ☐ Yes ☐ No

› Since your last visit, have there been changes in your teeth? ☐ Yes, describe: _____ ☐ No

4. Have you experienced any of the following in recent months (check all that apply):

☐ Excessive sweating
☐ Weight gain: ____ lb in weeks/months (circle one)
☐ Weight loss: ____ lb in weeks/months (circle one)
☐ Palpitation (fluttering) of the heart
☐ Emotional/mood swings
☐ Clumsiness in arms or legs
☐ Shaking or tremors in your body movements
☐ Double vision
☐ Numbness of the face or extremities
☐ Tingling around the mouth or face
☐ Burred vision or blindness
☐ Weakness or paralysis of the face
☐ Confusion or loss of consciousness
☐ Memory Change

5. Describe your current diet:

› Solids (choose one that best describes your diet)

☐ Any solid foods
☐ Foods are solid but moist; I avoid dry foods or those that are difficult to chew
☐ Foods must be chopped with gravy or sauce to moisten
☐ All solids are pureed
☐ No solids

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› Liquids (choose one that best describes your diet)

☐ Any liquids
☐ Thicken liquids to nectar consistency
☐ Thicken liquids to honey consistency
☐ Pudding thick consistency only
☐ No liquids

› Nothing or limited intake by mouth:

☐ Tube feeding and limited oral intake
☐ Tube feeding and no oral intake
☐ NA

› Has your swallow problem caused you to eat less? ☐ Yes ☐ No
If yes, how much less? ☐ 25% ☐ 50% ☐ 75% ☐ 100%

6. Since your initial evaluation,

› Have you had swallowing therapy for your concerns? ☐ Never ☐ Yes, in past ☐ Yes, currently
if yes, please describe:

Number of sessions _____ (#/wk) for the period of time _____ (months)
Length of each session _____ (minutes)
Service provider _____ location (city, state) _____
Approximate date when therapy started _____ when therapy ended _____
Goals of therapy _____
Was the therapy beneficial? ☐ Yes ☐ No

› Have you quit using tobacco? ☐ Yes ☐ No ☐ Not applicable
If so, when did you quit? _____ (month/year)

7. Please rate how the following problems have affected you within the past month

	"0" = No problem					"5" = Severe problem
Hoarseness or a problem with your voice	0	1	2	3	4	5
Clearing your throat	0	1	2	3	4	5
Excess throat mucus or post nasal drip	0	1	2	3	4	5
Difficulty swallowing foods, liquids, or pills	0	1	2	3	4	5
Coughing after you eat or lie down	0	1	2	3	4	5
Breathing difficulties or choking episodes	0	1	2	3	4	5
Troublesome or annoying cough	0	1	2	3	4	5
Sensations of something sticking in your throat, or a lump in your throat	0	1	2	3	4	5
Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5
	(For staff input only) **RSI score**: _____					

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8. To what extent are the following scenarios problematic for you:

	"0" = No problem				"4" = Severe problem
My swallowing problem has caused me to lose weight	0	1	2	3	4
My swallowing problem interferes with my ability to go out for meals	0	1	2	3	4
Swallowing liquids takes effort	0	1	2	3	4
Swallowing solids takes extra effort	0	1	2	3	4
Swallowing pills takes extra effort	0	1	2	3	4
Swallowing is painful	0	1	2	3	4
The pleasure of eating is affected by my swallowing	0	1	2	3	4
I cough when I eat	0	1	2	3	4
Swallowing is stressful	0	1	2	3	4

(For staff input only) **EAT score**: _____

SF-12v2® Health Survey Standard Version

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. **In general, would you say your health is:** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. **The following two questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:			
b. Climbing several flights of stairs:			

3. **During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular activities as a result of your physical health?**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like					
b. Were limited in the kind of work or other activities:					

4. **During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like:					
b. Did work or activities less carefully than usual					

5. **During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?** ☐ Not At All ☐ A Little Bit ☐ Moderately ☐ Quite a Bit ☐ Extremely

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6. **These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?					
b. Did you have a lot of energy?					
c. Have you felt downhearted and depressed?					

7. **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**

☐ All the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time