


ECKELMANN-TAYLOR SPEECH AND HEARING CLINIC
Illinois State University

Adult Swallow Case History

Name: _____

Other names, if applicable: _____ Pronouns: _____

Date of Birth: _____ ☐ Male ☐ Female ☐ Other

Address: _____

City: _____

State: _____ Zip Code: _____

Primary Phone: _____

Name of person who referred you to the clinic: _____

HISTORY OF PROBLEM

Please describe the swallowing problem: _____

_____

Please describe when the swallowing problem began: _____

_____

Have you ever had a swallow evaluation or treatment? _____ Yes _____ No

If yes, please describe: _____

_____

Have you ever had a Modified Barium Swallow Study? _____ Yes _____ No

If yes, please indicate the date and results: _____

_____

Have you ever had a Fiberoptic Endoscopic Evaluation of Swallowing (FEES)? _____ Yes _____ No

If yes, please indicate the date and results: _____

_____

CURRENT STATUS

What is the consistency of the food that you are currently eating? (Please check)

_____ Regular food _____ Soft food

_____ Pureed food _____ No food by mouth

What is the consistency of liquids that you are currently drinking? (Please check)

_____ Regular/thin liquids _____ Nectar consistency liquids

_____ Honey consistency liquids _____ No liquids by mouth

Which of the following problems are you currently experiencing? (Check all that apply)

_____ Drooling during non-meal times

_____ Losing (food/liquid/both) from your mouth during meals

_____ Difficulty drinking from a straw

_____ Difficulty chewing

_____ Difficulty moving (food/liquid/both) out of the mouth and into the throat

_____ Difficulty starting the swallow

_____ Pain during swallow

_____ Coughing/choking on (food/liquid/both)

_____ After swallowing, frequent throat clearing or coughing

_____ Sensation of food sticking in throat

_____ Difficulty swallowing pills

_____ Wet, gurgly vocal quality during meals

Have you had recent weight loss? _____ Yes _____ No

If yes, how much weight? _____

Do you have any food allergies? _____ Yes _____ No

If yes, please explain: _____

PERTINENT MEDICAL HISTORY

Check pertinent conditions:

_____ Reflux/gastroesophageal reflux disease (GERD)

_____ Esophageal disorder

_____ History of aspiration pneumonia

_____ Asthma

_____ Frequent upper respiratory infections

_____ Sinus problems

_____ Stroke

_____ Heart conditions

_____ Surgeries If yes, what type and when? _____

_____ Allergies If yes, how do you treat them? _____

Other, explain: _____

_____

What medications are you currently taking or have recently taken? _____

_____