MIDWESTERN UNIVERSITY
COLLEGE OF HEALTH SCIENCES
SPEECH-LANGUAGE PATHOLOGY PROGRAM

Speech-Language Institute
Adult Case History: Swallowing Addendum

Please complete and return prior to the first appointment.

Fax: 623-806-7708 | 5815 W. Utopia Road Glendale, AZ 85308

Client Information	*Date Completed:*
Name: _____ _____ _____ *First (Preferred name) Middle Initial Last*	**Date of Birth:** _____

Swallowing Concerns

- ☐ **Coughing with food/drinks**
- ☐ **Feeling like food/drinks "get stuck"**
- ☐ **Feeling like food/drinks "come back up"**
- ☐ **Burning sensation with eating/drinking**
- ☐ **Difficulty breathing during or after eating/drinking**
- ☐ **Recent weight loss attributed to difficulty swallowing**
- ☐ **Feeling a "lump in the throat" even when not eating/drinking**
- ☐ **Difficulty chewing or moving food in the mouth**
- ☐ **Other:** _____

Description of Concern:

Swallowing History

When did swallowing symptoms begin? _____
Were other medical or life events occurring at that time?
_____
Have symptoms ☐ improved? ☐ worsened? ☐ remained consistent?
Please explain:

Are symptoms worse during certain meals/times of day? ☐Yes ☐ No
If yes, please describe: _____
Are symptoms worse with certain food/drinks? ☐Yes ☐ No
If yes, please describe: _____

Have you ever had a swallowing evaluation/screening? ☐Yes ☐ No
If yes, where and when? _____
What were the results?

Have you ever had a study that visualized your swallowing with an x-ray or a nasal scope?
☐Yes ☐ No
If yes, where and when?
What were the results?

Have you ever been enrolled in swallowing therapy, or are you currently participating in swallowing therapy? ☐Yes ☐ No
If so, where?
How long?
Please describe services and progress:

Pertinent Medical History

Do you have a history of acid reflux/GERD? ☐Yes ☐ No
If so, what sorts of treatments are you currently using?
Do you feel your reflux is well managed?
Do you still have symptoms?
Do you have a history of esophageal stenosis/strictures? ☐Yes ☐ No
If so, have you ever had surgery/dilation? ☐Yes ☐ No
If yes, how frequently do you undergo this procedure, and when was your most recent?
Have you ever been diagnosed with aspiration pneumonia? ☐Yes ☐ No
If so, how many times, and when was your most recent diagnosis?
Do you have a history of COPD or other respiratory disorders? ☐Yes ☐ No
If so, would you consider your COPD to be worsening? ☐Yes ☐ No

Diet Consistency

Do you alter your <u>foods</u> in any way to make them easier to chew? ☐Yes ☐ No
If so, do you consume:
☐ Pureed foods (mashed potato/applesauce consistency)
☐ Soft foods (ground beef consistency)
☐ Other:
Do you alter your <u>drinks</u> in any way to make them easier to swallow? ☐Yes ☐ No
If so, do you consume:
☐ Nectar thick liquids
☐ Honey thick liquids
☐ Other:
Has a speech-language pathologist or other healthcare provider ever indicated that you should be altering your food/drink textures? ☐Yes ☐ No
If so, what were the results?

Compensatory Strategies

Do you complete any of the following strategies when you swallow?

☐ **Chin tuck/Chin down** ☐ **Head turn left** ☐ **Head turn right** ☐ **Head tilt**
☐ **Immediate cough** ☐ **Pushing/pulling against resistance** ☐ **Chin up**
☐ **Holding food/liquid in your mouth**
☐ **Other maneuvers:**

Has a speech-language pathologist or other healthcare provider ever indicated that you should be using one of the above strategies when you swallow? ☐**Yes** ☐ **No**
If so, what were the results?

Additional Swallowing Concerns