



**ADULT SPEECH/LANGUAGE PATHOLOGY  
SWALLOWING CASE HISTORY ATTACHMENT**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please describe the swallowing problem: \_\_\_\_\_

Onset of swallowing problem: ☐ gradual ☐ sudden ☐ past few weeks ☐ past few months ☐ 6 – 12 months  
☐ over \_\_\_\_ years

Has the problem changed over time? ☐ Improved ☐ Gotten worse ☐ Same

Have you received previous swallowing evaluations and/or treatment? ☐ NO ☐ YES

If yes, list dates, name, location and phone number: \_\_\_\_\_

Please describe the consistency of foods and liquids you are currently eating:

☐ Regular foods ☐ Cut up or soft foods ☐ Finely chopped ☐ Puree

☐ Thin liquids ☐ Nectar thick liquids ☐ Honey thick liquids

☐ Other \_\_\_\_\_

Do you have a feeding tube? ☐ No ☐ Yes (date placed): \_\_\_\_\_

Amount/type of feeding per day: \_\_\_\_\_

How do you take Medication? \_\_\_\_\_

Have you had a recent weight loss? ☐ No ☐ Yes \_\_\_\_# of lbs. over \_\_\_\_ weeks/months.

Describe your appetite: ☐ Good ☐ Fair ☐ Poor

Do you have dietary restrictions or have you eliminated any foods from your diet?

☐ No ☐ Yes (Please state restrictions) \_\_\_\_\_

Food Allergies ☐ No ☐ Yes \_\_\_\_\_

Please describe any management strategies you are using to swallow your current diet: \_\_\_\_\_

Length of meal time: ☐ < 20 minutes ☐ 20 - 30 minutes ☐ > 30 minutes

Do you require any assistance with your meals? ☐ NO ☐ YES (describe) \_\_\_\_\_

Do you wear dentures? ☐ No ☐ Yes Circle: Upper / Lower / Partial

What is your current physical status? ☐ Walk ☐ Cane ☐ Wheelchair

Can you support your upper body? ☐ No ☐ Yes head? ☐ No ☐ Yes

Please describe your voice: ☐ Normal ☐ Hoarse ☐ Hoarse ☐ Weak ☐ No voice

Do you experience any of the following? (Check all that apply)

- |                                                         |                                                                                      |
|---------------------------------------------------------|--------------------------------------------------------------------------------------|
| <input type="checkbox"/> Poor morning voice quality     | <input type="checkbox"/> Throat soreness or burning sensation not related to illness |
| <input type="checkbox"/> Frequent throat clearing       | <input type="checkbox"/> Coughing episodes not related to illness/swallowing         |
| <input type="checkbox"/> Increased phlegm in the throat | <input type="checkbox"/> Heartburn (If checked, how many times per week? ____)       |
| <input type="checkbox"/> Tastes repeating after meals   | <input type="checkbox"/> Feeling of a lump in the throat when swallowing             |
| <input type="checkbox"/> Increased throat/mouth dryness | <input type="checkbox"/> Bad taste in the mouth (sour, acidic, metallic)             |
| <input type="checkbox"/> Frequent hiccups               | <input type="checkbox"/> Unpredictable/variable voice quality during the day         |
| <input type="checkbox"/> Feeling of throat tightness    | <input type="checkbox"/> Increased coughing when lying down                          |

Do you take any medication for reflux? ☐ No ☐ Yes \_\_\_\_\_

Please write down any additional information you feel will help us understand your swallowing problem: \_\_\_\_\_

Speech Pathologist's Notes: \_\_\_\_\_

# Sample Case History Report Speech Pathology

**VM Jensen**



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