



**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

Sally K. Gallena



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