**ADULT FEEDING CASE HISTORY**

**Feeding & Swallowing**

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

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Start of swallowing problem:

Please check one: \_\_\_\_\_\_ gradual \_\_\_\_\_sudden

Please check one: \_\_\_\_past few weeks \_\_\_\_\_past few months \_\_\_\_6-12+ months

Previous swallow evaluation or treatment: \_\_\_\_\_\_Yes \_\_\_\_\_\_No

If yes:

Modified Barium Swallow Study (MBS): \_\_\_\_\_\_Yes \_\_\_\_\_\_No

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Fiberoptic Endoscopic Evaluation of Swallowing (FEES): \_\_\_\_ Yes \_\_\_\_No

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Swallowing treatment performed with a Speech-Language Pathologist: \_\_\_\_Yes \_\_\_\_No

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What is the consistency of food and liquid that you are currently eating?:

Solids: \_\_\_\_\_\_\_Regular \_\_\_\_\_\_Soft \_\_\_\_\_\_Puree

Liquids: \_\_\_\_\_\_Thin/Regular \_\_\_\_\_\_Nectar-thick \_\_\_\_\_\_Honey-thick

\_\_\_Nothing by mouth (NPO) If checked: Do you have a feeding tube? \_\_\_\_Yes \_\_\_\_No

Date placed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentition/Teeth: \_\_\_\_\_\_Natural \_\_\_\_\_\_\_Dentures **(upper/lower/both)**

**\_\_\_\_\_\_**Bridge \_\_\_\_\_\_\_Missing teeth \_\_\_\_\_\_No teeth

Do you require assistance with your meals?: \_\_\_\_\_\_Yes \_\_\_\_\_\_No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Check the problems you are currently experiencing:** (check all that apply)

\_\_\_\_drooling during non-mealtimes

\_\_\_\_losing **(food/liquid/both)** from your mouth during meals

\_\_\_\_difficulty drinking from a straw

\_\_\_\_difficulty chewing

\_\_\_\_difficulty moving **(food/liquid/both)** out of mouth and into throat

\_\_\_\_difficulty starting the swallow

\_\_\_\_pain during swallowing

\_\_\_\_**(food/liquid/both)** coming out of nose

\_\_\_\_coughing/choking on **(food/liquid/both)**

\_\_\_\_after swallowing, frequent **(throat clearing/coughing/both)**

\_\_\_\_sneezing during meals

\_\_\_\_runny nose during meals

\_\_\_\_eye watering during meals

\_\_\_\_sensation of food sticking **(throat/chest/both)**

\_\_\_\_difficulty swallowing pills

\_\_\_\_need to avoid certain **(foods/liquids/both)**

\_\_\_\_regurgitation or being unable to keep down certain **(foods/liquids/both)**

\_\_\_\_burping **(during/after/throughout)** meals

\_\_\_\_coughing or choking on saliva during non-mealtimes

\_\_\_\_sudden coughing after lying down

\_\_\_\_waking at night choking or coughing

\_\_\_\_thickened or excess mucus or secretions

\_\_\_\_ulcers or sores in mouth

\_\_\_\_dry mouth

\_\_\_\_unpredictable or variable voice quality during the day

Have you had recent weight loss?: \_\_\_\_\_\_Yes \_\_\_\_\_\_No

If yes, \_\_\_\_\_\_\_# of pounds over \_\_\_\_\_\_\_\_\_weeks/months

Describe your appetite: \_\_\_\_\_\_Good \_\_\_\_\_\_Fair \_\_\_\_\_\_Poor

Dietary restrictions or foods you eliminated: \_\_\_\_\_\_Yes \_\_\_\_\_\_No

If yes, please state: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food allergies: \_\_\_\_\_\_Yes \_\_\_\_\_\_No

If yes, please state: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of meal time: \_\_\_\_less than 20 min \_\_\_\_20-30 min \_\_\_\_greater than 30 min

Any strategies that help you swallow?: \_\_\_\_\_\_Yes \_\_\_\_\_\_No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your voice: \_\_Normal \_\_Hoarse \_\_Breathy \_\_Weak \_\_No voice

Current physical status: \_\_\_\_\_\_Walk \_\_\_\_\_\_Cane \_\_\_\_\_\_Wheelchair

Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Pertinent Medical History**

Reflux/Gastroesophageal reflux disease (GERD)/Laryngopharyngeal reflux (LPR)

\_\_\_\_\_\_\_Yes (please circle which) \_\_\_\_\_\_No

Esophageal disorder: \_\_\_\_\_\_Yes \_\_\_\_\_\_No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of aspiration pneumonia: \_\_\_\_\_\_ Yes \_\_\_\_\_\_\_No

If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurological deficits: \_\_\_\_\_\_Yes \_\_\_\_\_No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart problems/disorders: \_\_\_\_\_\_Yes \_\_\_\_\_\_No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lung/breathing disorders: \_\_\_\_\_\_Yes \_\_\_\_\_\_No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head/Neck Cancer: \_\_\_\_\_\_Yes \_\_\_\_\_\_No

If yes: location, type, and date of diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Surgery and dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Chemotherapy/Radiation (Circle one or both) Current/Completed (Circle one)

Please provide any additional information that you feel will help us understand your

swallowing problem or any goals you may have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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