

Swallowing Inventory

Client: _____ Disorder: _____
Informant: _____ Date: _____
Student Clinician(s): _____

Ask the client or the caregiver the following questions:

1. Do you have trouble swallowing or eating? Yes/No

2. Do you drool when you drink? Yes/No

3. Do you cough or become choked when you eat? Yes/No

4. Has anyone ever told you that you have a swallowing problem or difficulty swallowing? Yes/No
If yes, when were you told this? _____
Who told you this? _____
5. Have you ever had therapy for swallowing problems in the past? Yes/No _____
6. Have you ever had a modified barium swallow study or a cookie swallow study? Yes/No _____

*****IF ANY QUESTION IS ANSWERED WITH A "YES," GIVE A COPY OF THIS TO YOUR SUPERVISOR IMMEDIATELY FOR FURTHER DISCUSSION AND/OR FOLLOW-UP.***