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.**