Boulder Community Health

Outpatient Rehabilitation Services
Swallowing Therapy
Adult Patient Intake Questionnaire

Name: _____ Date of Birth: _____
Today's Date: _____ Age: _____
Referring Physician: _____ Primary Dr: _____
Date of onset: _____
Reason for referral:

❒ Amyotrophic Lateral Sclerosis (ALS)
❒ Brain Injury
❒ Cancer:
  ❑ Chemotherapy
  ❑ Radiation
❒ Concussion
❒ Multiple Sclerosis (MS)
❒ Parkinson's Disease
❒ Spinal Cord Injury
❒ Stroke
❒ Surgery: _____
❒ Other: _____

1. How would you describe your health today? ❒ *Excellent* ❒ *Very Good* ❒ *Fair* ❒ *Poor*
2. Describe the injury, incident or diagnosis (include time, place, symptoms experienced).

_____

_____

_____

3. What treatment have you received since the onset of difficulties? (Please list hospitalizations, healthcare providers or therapists as best as you can) _____

_____

_____

4. Diagnostic Tests:
   ❒ *CT* ❒ *MRI* ❒ *Xray* ❒ *Swallow Test* ❒ *Endoscopy* ❒ *Neuropsychological Test*
   Other: _____
5. Do you have any other medical problems? ❒ *Yes* ❒ *No*

If yes, please explain: _____

_____

6. Significant surgical history: _____

_____

7. Allergies (Drug, Food, Environmental): _____

_____

_____
Patient Label or Name and DOB

8. Current medications and supplements: _____

_____

9. What are your <u>specific goals</u> for swallowing therapy? _____

_____

_____

10. Are you 65 or older? ❒ *Yes* ❒ *No*
11. Have you had 2 or more falls in the past year? ❒ *Yes* ❒ *No*
12. Have you had any injury from a fall in the past year? ❒ *Yes* ❒ *No*

<u>Current Nutrition Status:</u>

- ❑ Regular diet for solid food
- ❑ Regular liquids
- ❑ Modified diet (e.g. soft or chopped foods only)

Thickened liquids:

- ❑ Nectar-thick
- ❑ Honey-thick

No oral intake: ❒ PEG ❒ NG/Dobhoff ❒ Other

1. How much of your daily food and drink intake do you eat by mouth?
   ❒ *All* ❒ *More than half* ❒ *Half* ❒ *Less than half* ❒ *None*
2. How much of your daily food and drink intake comes through a feeding tube?
   ❒ *All* ❒ *More than half* ❒ *Half* ❒ *Less than half* ❒ *None*
3. Do you frequently use straws with liquids? ❒ *Yes* ❒ *No*
4. Do you avoid certain foods because of your swallowing difficulties? ❒ *Yes* ❒ *No*

*If yes, please explain:*_____

5. Does it take you longer to eat a meal than others? ❒ *Yes* ❒ *No*
6. When do you have difficulty at mealtimes?
   ❒ *Beginning* ❒ *Middle* ❒ *End* ❒ *Throughout*
7. How frequently do you have trouble? ❒ *All the time* ❒ *Sometimes* ❒ *Occasionally*

<u>Swallowing</u>- <u>Please check the box if you are having challenges in any of these areas</u>:

- ❑ Chewing
- ❑ Choking while eating/drinking
- ❑ Coughing on liquids
- ❑ Coughing on solids
- ❑ Difficulty with pills
- ❑ Frequent throat clearing
- ❑ Food left in mouth after swallow
- ❑ Feel full after eating small amounts
- ❑ Frequent belching
- ❑ Increased coughing after meals
- ❑ Increased coughing at night
- ❑ Irregular bowel movements
- ❑ Losing control of food/ mouth spillage
- ❑ Memory or cognitive changes
- ❑ Nasal spillage of food/liquid
- ❑ Need multiple swallows
- ❑ Regurgitation
- ❑ Saliva management/drooling
- ❑ Sensation of food stuck: Where?_____
- ❑ Sinus drainage
- ❑ Ulcers/Sores in mouth
- ❑ Weakness- mouth
- ❑ Weakness – lips
- ❑ Wet/gurgly voice during or after meal

_____

Patient Label or Name and DOB

Have you seen a gastro- (GI) doctor before? ❒ *Yes* ❒ *No*

- ❑ History of gastro-intestinal reflux (GERD)
- ❑ History of laryngopharyngeal reflux (LPRD)
- ❑ Other GI history:_____

_____

Please describe how you were doing before the onset of these problems: _____

_____

_____

❒ Right handed ❒ Left handed

Home/ Social/ Community

1. Home Situation: ❒ *house* ❒ *apartment* ❒ *condo/townhome*
2. Where:
   ❒ *Boulder* ❒ *Broomfield* ❒*Lafayette* ❒ *Louisville* ❒*Erie* ❒ *Other:* _____
3. Relationship status: ❒ *single* ❒ *married* ❒ *divorced* ❒ *dating*
4. Who do you live with? _____
5. Children: ❒ *Yes* ❒ *No* Grandchildren: ❒ *Yes* ❒ *No*
6. Pets:_____
7. Do you feel safe at home? ❒ *Yes* ❒ *No*

Education/Occupation

1. Are you currently working or going to school? ❒ *Yes* ❒ *No* ❒ *Retired* ❒ *On Disability*
2. Education : ❒ *GED* ❒*high school* ❒*some college* ❒ *Bachelor's* ❒ *Master's*
   ❒ *PhD* ❒ *Tech/Vocational*
3. What is/was your area of study? _____

   _____
4. Learning Style: ❒ *Doing* ❒ *Visual* ❒ *Listening* ❒ *Reading/Written handouts*
5. What do you do for work? _____
6. How many hours do you work per week? _____
7. Did you take any time off from work? ❒ *Yes* ❒ *No*
   If yes, how long? Why? _____

   _____

   _____
8. Do you volunteer? Describe:

   _____
9. Hobbies/Interests/Social Life: _____

   _____

   _____
10. What do you do for exercise? _____
11. How often? _____

_____

Patient Label or Name and DOB

Physical:

- ❑ decreased balance
- ❑ decreased endurance
- ❑ headaches
- ❑ Jaw pain/TMJ
- ❑ nausea
- ❑ pain
- ❑ paralysis
- ❑ vertigo

Psychosocial/Emotional:

- ❑ anxiety
- ❑ anger control/temper outbursts
- ❑ change in sex drive
- ❑ depression
- ❑ driving anxiety
- ❑ flashbacks
- ❑ easily upset or angry, cries easily
- ❑ frustration
- ❑ grief and loss issues
- ❑ irritability
- ❑ panic attacks
- ❑ relationship difficulties
- ❑ sleep problems
- ❑ stress

1. Who is part of your support system?

   _____

   _____

2. How are they helping you?

   _____

   _____

3. Have you participated in mental health therapy or counseling before? ❒ *Yes* ❒ *No*

Appetite:

Check all that apply:

- ❑ Same – no problems
- ❑ No appetite
- ❑ Increased appetite
- ❑ Decreased appetite
- ❑ Forget to eat
- ❑ Gained weight
- ❑ Lost weight
- ❑ Decreased sense of taste or smell

# of meals/day_____ # of snacks_____

Substance Use:

1. # Caffeinated drinks_____
2. Do you drink alcohol? ❒ *Yes* ❒ *No*

   If yes: # of alcoholic drinks _____ ❒ *Per day* ❒ *Weekly* ❒ *Socially*
3. Do you smoke tobacco? ❒ *Yes* ❒ *No*
4. Do you use any recreational drugs? ❒ *Yes* ❒ *No*

   How often? _____

_____

Patient Label or Name and DOB

Hearing
Check all that apply:

- ❑ No difficulties
- ❑ Tinnitus/ringing in the ears
- ❑ Sensitivity to noise
- ❑ Decreased hearing acuity
- ❑ Decreased auditory processing

Do you wear hearing aids? ❒ *Yes* ❒ *No*
Do you wear them consistently? ❒ *Yes* ❒ *No*
Do they help you? ❒ *Yes* ❒ *No*

Vision
Check all that apply:

- ❑ Glasses for reading
- ❑ Glasses for vision
- ❑ Contact lenses
- ❑ No difficulties
- ❑ Blurry vision
- ❑ Sensitivity to light
- ❑ Double vision
- ❑ Decreased peripheral vision
- ❑ Headaches with reading
- ❑ Decreased tracking abilities

Driving/Transportation

Do you have any difficulties with driving? ❒ *Yes* ❒ *No*
If yes, please explain: _____
_____

Cultural/Spiritual Concerns

Do you have any cultural or spiritual concerns that we should consider during your therapy? _____

_____

_____
Patient Signature **Date/Time**

Thank you! Please turn this questionnaire in to the Outpatient Rehabilitation check in desk during the check in process the day of your evaluation.

_____
Patient Label or Name and DOB