Swallowing Disorder (Dysphagia) Intake Form

Patient Information

Full Name

Date of Birth

Phone Number

Email Address

Address

Medical History

Primary Diagnosis/Reason for Referral

Relevant Medical Conditions (e.g., stroke, Parkinsonâ€™s, etc.)

Current Medications

Allergies

Swallowing Concerns

Onset of Swallowing Difficulty

Specific Foods/Textures Causing Difficulty

Swallowing Symptoms

Coughing during/after eating
Choking
Wet/gurgly voice
Pain while swallowing
Frequent throat clearing
Food sticking in throat
Unexplained weight loss

Other Symptoms

Diet & Nutrition

Current Diet (e.g., regular, pureed, etc.)

Type of Liquids Consumed (e.g., thin, thickened, etc.)

Do you require assistance with feeding?

Additional Information

Goals for Therapy/Assessment

Any Additional Comments or Questions