Oroville Hospital

Swallowing Questionnaire

Have you experienced difficulty swallowing solid foods, liquids, or both?

How often does your swallowing problem occur (e.g. occasionally, daily, every meal)?

How long have you had difficulties with swallowing?

Did the problem begin gradually or suddenly?

Have you changed your diet so it is easier to swallow? Yes ◯ No ◯

If you checked yes, please describe your diet:

Do you smoke tobacco? Yes ◯ No ◯ or Other ◯

If yes or other, how many times per day?

	Yes	No
Are you experiencing indigestion or a burning sensation in your chest?	◯	◯
Do you cough or clear your throat during or after eating and drinking?	◯	◯
Do you feel a "lump" in your throat when you swallow?	◯	◯
Do you experience pain when you swallow?	◯	◯
Do you have trouble chewing your food?	◯	◯
Does it take you a long time to eat?	◯	◯
Do you find food remains in your mouth after eating/drinking?	◯	◯

Do you have any additional concerns regarding your swallow difficulties? If so, please explain:

Health History

Check any that you have had or currently have:

	Yes	No		Yes	No
Heart Disease	◉	○	Asthma	◉	○
Seizure Disorder	◉	○	COPD	◉	○
Stroke	◉	○	Concussion	◉	○
Migraine Headaches	◉	○	Head Injury	◉	○
Tuberculosis	◉	○	Allergies	◉	○
Diabetes	◉	○	Pacemaker	◉	○
Cancer	◉	○	Defibrillator	◉	○
High Blood Pressure	◉	○	Double Vision	◉	○

Other diagnosis that may be relevant to our treatment, please explain:

Do you currently:	Yes	No
Using hearing aids?	◉	○
Use glasses?	◉	○
Have difficulty sleeping?	◉	○
Have issues with your living situation?	◉	○
Have relationship problems?	◉	○
Get bothered by feeling down, hopeless or anxious?	◉	○
Experience a lack of energy for daily tasks?	◉	○
Have questions about services and how to obtain them?	◉	○

Would you like to be referred to a social worker who can help (no cost and CONFIDENTIAL)?

Yes ◉ **No** ○

Pain Management

Are you in pain right now? Yes ◉ **No** ○

If yes, please rate your pain from 1 - 10 (1 being the least, 10 being the worst pain imaginable):

1	2	3	4	5	6	7	8	9	10
○	○	○	○	◉	○	○	○	○	○

Location(s) of pain:

Medicare Secondary Payor Screening

1. Is this hospitalization caused by an automobile or other accident possibly covered by another insurance (e.g. Veterans Administration, Group Health Plan, etc.)?
   Yes ◉ No ○

2. Is this hospitalization caused by an accident or illness that occurred at work?
   Yes ◉ No ○

3. Do you or your spouse work for a company that provides you with health insurance?
   Yes ◉ No ○

Patient's Signature:

Date:

Please read the following carefully:

- Your regular participation in therapy and follow through with your home program is essential to your recovery. It is important for you to keep scheduled appointments, please call our front desk (530-712-2196) as soon as possible (we appreciate at least a 24 hour notice) so that we may offer the appointment to another patient.

- If you have three missed appointments, whether canceled or no show/no call, this may result in a discharge from therapy services at the discretion of the therapist.

We look forward to partnering with you in your rehabilitation process and appreciate you choosing Golden Valley Outpatient Rehabilitation!

I acknowledge that I understand the policies and have completed this form to the best of my knowledge.

Patient's Signature:

Date:

SUBMIT