

**Craig H. Zalvan, MD, FACS**  
**The Institute for Voice and Swallowing Disorders**  
**Swallow Intake Form**

**Please fill out this form in black ink as completely as possible and bring to your scheduled Appointment.**

**IDENTIFYING INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Profession: \_\_\_\_\_

**HISTORY OF PRESENT SWALLOWING/THROAT COMPLAINT:**

1. Describe your problem:

- a. Current Diet:
- b. Current Feeding Status (Oral, Feeding Tube):
- c. Do you have trouble swallowing certain foods ?  Solids  Liquids  Both  Neither
  - i. Describe:
- d. Do you cough if you eat/drink ?  Solids  Liquids  Both  Neither
- e. Have you had pneumonia in the past ? When ?

2. Estimate the severity of the problem:

1 – not at all      2 – mild      3 – Moderate      4 - Severe

3. When did you first notice the throat/swallow problem?

4. Onset of problem:  Sudden       Gradual

5. On a scale of 0 (none) to 10 (severe), what is your level of pain associated with your swallowing/throat problem ? \_\_\_\_\_

6. Were any events associated with the onset of your problem ? (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Swallowed an object                        | <input type="checkbox"/> Surgery         |
| <input type="checkbox"/> Medical Illness (stroke, diabetes, etc...) | <input type="checkbox"/> Injury (trauma) |
| <input type="checkbox"/> Upper respiratory infection (cold/flu)     | <input type="checkbox"/> None            |
| <input type="checkbox"/> Other (specify):                           |  |

7. What do you think is the cause of your throat/swallow problem:

8. Is the problem getting:     Better         Worse         Same         Fluctuates

9. Swallowing during the day:  Better         morning     afternoon    evening  
    Worse         morning     afternoon    evening

10. Please check all that apply to you:

- |   |  |
|---|--|
| <input type="checkbox"/> Hoarseness   | <input type="checkbox"/> Frequent throat clearing                        |
| <input type="checkbox"/> Fatigue (voice tires easily)   | <input type="checkbox"/> Heartburn                                       |
| <input type="checkbox"/> Voice too loud   | <input type="checkbox"/> Belching  |
| <input type="checkbox"/> Voice too soft/weak  | <input type="checkbox"/> Dry mouth or throat                             |
| <input type="checkbox"/> Pitch too high   | <input type="checkbox"/> Sensation of phlegm in throat                   |
| <input type="checkbox"/> Pitch too low  | <input type="checkbox"/> Tickling or choking sensation                   |
| <input type="checkbox"/> Frequent voice breaks  | <input type="checkbox"/> Tightness or tension in throat                  |
| <input type="checkbox"/> Breathiness  | <input type="checkbox"/> Something stuck/Lump in throat                  |
| <input type="checkbox"/> Raspiness  | <input type="checkbox"/> Hard and abusive laughter                       |
| <input type="checkbox"/> Frequent yelling or loud talking   | <input type="checkbox"/> Frequent thirst/dehydration                     |
| <input type="checkbox"/> Frequent whispering  | <input type="checkbox"/> Pain in throat while talking                    |
| <input type="checkbox"/> Hard or Frequent coughing  | <input type="checkbox"/> Bad/acid taste/breath                           |
| <input type="checkbox"/> Losing your voice completely   | <input type="checkbox"/> Frequent sore throat                            |
| <input type="checkbox"/> Straining or effort in speaking  | <input type="checkbox"/> Post-Nasal drip                                 |
| <input type="checkbox"/> Loss of range ? <input type="checkbox"/> High <input type="checkbox"/> Low | <input type="checkbox"/> Difficulty swallowing                           |
| <input type="checkbox"/> Run out of air when speak/sing   | <input type="checkbox"/> Coughing with food/drink                        |
| <input type="checkbox"/> Tremulous voice  | <input type="checkbox"/> Lecturing                                       |
| <input type="checkbox"/> Noisy breathing  | <input type="checkbox"/> Yelling (sports event, house, kids)             |
| <input type="checkbox"/> Neck/Back Pain   | <input type="checkbox"/> Aggressive personality                          |
| <input type="checkbox"/> Calling kids/pets from a distance  | <input type="checkbox"/> Exposure to dust, fumes, chemicals              |
| <input type="checkbox"/> Nasal voice  | <input type="checkbox"/> Loud or strenuous singing                       |
| <input type="checkbox"/> Cheerleading or pep club   | <input type="checkbox"/> Imitating Voices/Sounds                         |
| <input type="checkbox"/> Seasonal Problem   | <input type="checkbox"/> Frequent exercise (grunting, lifting, aerobics) |
| <input type="checkbox"/> Breathing Difficulties   | <input type="checkbox"/> Choking episodes                                |
| <input type="checkbox"/> Other (explain)  | <input type="checkbox"/> None  |

11. Situations that:    Worsen the throat:  
   Improve the throat:

12. Previous swallow problems ?     No    Yes, describe:

13. Previous swallow therapy ?  No  Yes, describe (who, where, how long)
13. What treatments have you received for your throat/swallow problem ? Home remedies ?
14. Have you had any prior diagnostic tests ? If yes, what were the results ?
15. How would you rate your level of stress:  Low  Average  High

## Medical History

Do you have or have you had any problems listed below? Please check all that apply:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Heart attack   | <input type="checkbox"/> Liver disease           | <input type="checkbox"/> Osteoporosis               |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Hepatitis/Jaundice      | <input type="checkbox"/> Broken bones               |
| <input type="checkbox"/> Cardiomyopathy   | <input type="checkbox"/> Ulcers                  | <input type="checkbox"/> Neck/Back pain             |
| <input type="checkbox"/> Heart failure  | <input type="checkbox"/> Kidney disease/Stones   | <input type="checkbox"/> Stroke/TIA                 |
| <input type="checkbox"/> Pacemaker  | <input type="checkbox"/> Kidney failure/Dialysis | <input type="checkbox"/> Seizures                   |
| <input type="checkbox"/> Defibrillator/AICD   | <input type="checkbox"/> Crohn's/Colitis/IBD     | <input type="checkbox"/> Black out/Dizziness        |
| <input type="checkbox"/> Chest pain/Angina  | <input type="checkbox"/> Hiatal Hernia           | <input type="checkbox"/> Parkinsons/Alzheimers      |
| <input type="checkbox"/> Angioplasty  | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Multiple Sclerosis         |
| <input type="checkbox"/> Irregular heart beat/EP study  | <input type="checkbox"/> Emphysema/COPD          | <input type="checkbox"/> ALS (Lou Gehrig's Disease) |
| <input type="checkbox"/> Previous heart catheterization   | <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Meningitis                 |
| <input type="checkbox"/> Poor circulation in legs   | <input type="checkbox"/> Bronchitis              | <input type="checkbox"/> Migraines/Headaches        |
| <input type="checkbox"/> Heart valve disease  | <input type="checkbox"/> Sickle cell disease     |   |
| <input type="checkbox"/> Heart surgery  | <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Excessive bleeding         |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Radiation therapy       | <input type="checkbox"/> Chemotherapy               |
| <input type="checkbox"/> Urinary problems   | <input type="checkbox"/> Endocrine disorder      | <input type="checkbox"/> Lupus                      |
| <input type="checkbox"/> Depression   | <input type="checkbox"/> Anxiety Disorder        | <input type="checkbox"/> Psychiatric disorder       |
| <input type="checkbox"/> Immunologic Disease  |  |   |
| <input type="checkbox"/> Diabetes/Hypoglycemia  | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Cataracts                  |
| <input type="checkbox"/> Cortisone/Prednisone last 12 mo.   | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Cleft palate               |
| <input type="checkbox"/> Retinopathy  | <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> Nephropathy                |
| <input type="checkbox"/> Sinus problems/post nasal drip   | <input type="checkbox"/> Thyroid problems        | <input type="checkbox"/> TMJ                        |
| <input type="checkbox"/> Polio  | <input type="checkbox"/> Head injury             | <input type="checkbox"/> Tubes, lines or drains     |
| <input type="checkbox"/> Trauma   | <input type="checkbox"/> Hearing aid(s)          | <input type="checkbox"/> Hearing Impairment         |
| <input type="checkbox"/> Neurologic problems (weakness, numbness, clumsiness, tremors/shaking, confusion) |  |   |
| <input type="checkbox"/> Assistive devices (prosthesis, cane, crutches, brace, walker, wheelchair)        |  |   |
| <input type="checkbox"/> Pregnant now or within the last three months                                     |  |   |
| <input type="checkbox"/> Other (specify):   |  |   |

Details of any problem checked above:

## Surgical History (check all that apply):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Tonsillectomy             | <input type="checkbox"/> Oral surgery     | <input type="checkbox"/> Thyroid surgery      |
| <input type="checkbox"/> Adenoidectomy             | <input type="checkbox"/> Tracheotomy      | <input type="checkbox"/> Radiation (Specify): |
| <input type="checkbox"/> Appendectomy              | <input type="checkbox"/> Lung surgery     | <input type="checkbox"/> Back/Neck surgery    |
| <input type="checkbox"/> Abdominal surgery         | <input type="checkbox"/> Heart surgery    | <input type="checkbox"/> Hysterectomy         |
| <input type="checkbox"/> Larynx/Vocal Fold surgery |   |   |
| <input type="checkbox"/> NONE                      | <input type="checkbox"/> Other (specify): |   |

Details of any surgeries checked above:

**Allergies** (Medications, food, iodine, latex, tape, novacaine, shellfish, environment)

- None Known
- Allergic to:

**Social History:**

Substance Usage, Diet (check all that apply):

- Smoke \_\_\_\_\_ packs per day for \_\_\_\_\_ years
  - Quit smoking; date: \_\_\_\_\_
- Alcoholic beverages \_\_\_\_\_ per day, \_\_\_\_\_ per week; Type: \_\_\_\_\_
- Diet pills: Name: \_\_\_\_\_, Amount: \_\_\_\_\_, How long: \_\_\_\_\_
- Caffeine beverages: \_\_\_\_\_ per day. Type:  Cola  Coffee  Tea
- Water Intake: \_\_\_\_\_ glasses/ounces per day
- Other drugs/substance usage: \_\_\_\_\_
- Any Chemical/Environmental exposure: \_\_\_\_\_
- Special Diet: \_\_\_\_\_

**Family History** (similar problems):



**Review of Systems: (Specify Side or Location if Applicable)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Ear pain                     | <input type="checkbox"/> Decreased hearing               | <input type="checkbox"/> Nasal obstruction     |
| <input type="checkbox"/> Vision problems              | <input type="checkbox"/> Runny nose                      | <input type="checkbox"/> Itchy nose/face       |
| <input type="checkbox"/> Trouble chewing              | <input type="checkbox"/> Trouble swallowing              | <input type="checkbox"/> Painful swallow       |
| <input type="checkbox"/> Regurgitation                |  |  |
| <input type="checkbox"/> Change in skin/hair          | <input type="checkbox"/> Dry skin                        | <input type="checkbox"/> Hair loss             |
| <input type="checkbox"/> Easily chilled               | <input type="checkbox"/> Hypersensitivity to temperature | <input type="checkbox"/> Easy fatigue          |
| <input type="checkbox"/> Excessive sweat              | <input type="checkbox"/> Night sweats                    | <input type="checkbox"/> Weight gain           |
| <input type="checkbox"/> Weight loss                  | <input type="checkbox"/> Fever                           | <input type="checkbox"/> Menopause             |
| <input type="checkbox"/> Jaw pain/tension             | <input type="checkbox"/> Neck pain/tension               | <input type="checkbox"/> Shoulder pain/tension |
| <input type="checkbox"/> Abdominal pain               | <input type="checkbox"/> Pain with breathing             |  |
| <input type="checkbox"/> Shaking/tremor               | <input type="checkbox"/> Falling                         | <input type="checkbox"/> Vertigo               |
| <input type="checkbox"/> Poor coordination            | <input type="checkbox"/> Seizures                        |  |
| <input type="checkbox"/> Insomnia                     | <input type="checkbox"/> Memory change                   | <input type="checkbox"/> Headache              |
| <input type="checkbox"/> Aphasia                      | <input type="checkbox"/> Stuttering                      | <input type="checkbox"/> Articulation Disorder |
| <input type="checkbox"/> Chronic cough                | <input type="checkbox"/> Trouble breathing               | <input type="checkbox"/> Shortness of breath   |
| <input type="checkbox"/> Heartburn/Indigestion/Reflux | <input type="checkbox"/> Constipation/Diarrhea           | <input type="checkbox"/> Nausea/Vomit/Diarrhea |
| <input type="checkbox"/> Chest Pain                   | <input type="checkbox"/> Palpitations                    | <input type="checkbox"/> Change in Urination   |
| <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Muscle pain                     | <input type="checkbox"/> Joint Pain            |
| <input type="checkbox"/> Easy Bruising                | <input type="checkbox"/> Allergies                       | <input type="checkbox"/> Itching               |
| <input type="checkbox"/> Rash                         |  |  |

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Details of those items checked above:

Please list any additional information that may be helpful in the diagnosis and treatment of your problem:

TABLE 1

Reflux Symptom Index (RSI)

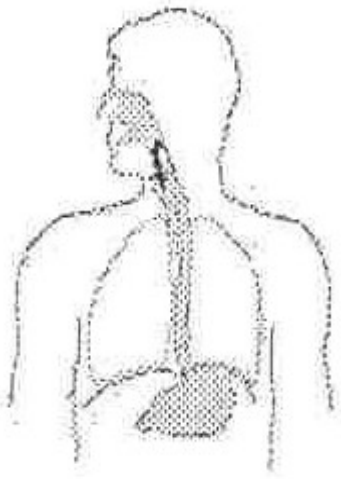
Within the last MONTH how did the following problems affect you?	0 = No Problem 5 = Severe Problem					
1. Hoarseness or a problem with your voice	0	1	2	3	4	5
2. Clearing your throat	0	1	2	3	4	5
3. Excess throat mucous or postnasal drip	0	1	2	3	4	5
4. Difficulty swallowing food, liquids, or pills	0	1	2	3	4	5
5. Coughing after you ate or after lying down	0	1	2	3	4	5
6. Breathing difficulties or choking episodes	0	1	2	3	4	5
7. Troublesome or annoying cough	0	1	2	3	4	5
8. Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
9. Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5

Voice Handicap Index (VHI-10), Henry Ford Hospital

Please circle the response that indicated how frequently you have these experiences:

0 = never 1 = almost never 2 = sometimes 3 = almost always 4 = always

My voice makes it difficult for people to hear me	0	1	2	3	4
People have difficulty understanding me in a noisy room.	0	1	2	3	4
My voice difficulties restrict my personal and social life.	0	1	2	3	4
I feel left out of conversations because of my voice.	0	1	2	3	4
My voice problem causes me to lose income.	0	1	2	3	4
I feel as though I have to strain to produce voice.	0	1	2	3	4
The clarity of my voice is unpredictable.	0	1	2	3	4
My voice problem upsets me.	0	1	2	3	4
My voice makes me feel handicapped.	0	1	2	3	4
People ask "What's wrong with your voice?"	0	1	2	3	4



Scripps Voice/Swallowing Center  
Voice Disorder Assessment

The Glottal Closure Index (GCI) is a four-question survey that assesses the clinical severity of voice disorders. The survey instrument is designed to be used by a physician or vocal specialist in conjunction with other pertinent patient history and physical examination findings. An abnormal GCI (> 2) may be indicative of a significant voice disorder. Please feel free to take and score your GCI below.

The Glottal Closure Index

A score > may indicate a significant voice disorder

Within the last month, how did the following problems affect you?	0 = no problem 5 = severe problem					
1. Speaking took extra effort	0	1	2	3	4	5
2. Throat discomfort or pain after using your voice	0	1	2	3	4	5
3. Vocal fatigue	0	1	2	3	4	5
4. Voice cracked or sound different	0	1	2	3	4	5
Total						