Stanford HEALTH CARE

Department of Rehabilitation Services
Swallowing Disturbance Questionnaire

Questions	0 = Never 1 = Seldom (once a month or less) 2 = Frequently (1-7 times a week) 3 = Very Frequently (> 7 times a week)			
1. Do you experience difficulty chewing solid food like an apple, cookie, or cracker?	0	1	2	3
2. Are there any food residues in your mouth, cheeks, under your tongue, or stuck to the roof of your mouth after swallowing?	0	1	2	3
3. Does food or liquid come out of your nose when you eat or drink?	0	1	2	3
4. Does chewed up food dribble from your mouth?	0	1	2	3
5. Do you feel you have too much saliva in your mouth (do you drool or have difficulty swallowing your saliva)?	0	1	2	3
6. Do you swallow chewed up food several times before it goes down your throat?	0	1	2	3
7. Do you experience difficulty in swallowing solid food (do apples or crackers get stuck in your throat)?	0	1	2	3
8. Do you experience difficulty in swallowing pureed food?	0	1	2	3
9. While eating, do you feel as if a lump of food is stuck in your throat?	0	1	2	3
10. Do you cough while swallowing liquids?	0	1	2	3
11. Do you cough while swallowing solid food?	0	1	2	3
12. Immediately after eating or drinking, do you experience a change in your voice, such as hoarseness or wetness?	0	1	2	3
13. Other than during meals, do you experience coughing or difficulty breathing as a result of saliva entering your windpipe?	0	1	2	3
14. Do you experience difficulty breathing during meals?	0	1	2	3
15. Have you suffered from a respiratory infection (such as pneumonia, bronchitis) in the past year? (Circle one)	YES		NO	