

## The Swallowing Disturbance Questionnaire

**0 = Never**      **1 = Seldom (1x/month or less)**      **2 = Frequently (1-7x/week)**  
**3 = Very Frequently (more than 7x/week)**

Do you experience difficulty chewing solid food like an apple, cookie or cracker?	0	1	2	3
Are there any food residues in your mouth, cheeks, under your tongue or stuck to your palate after swallowing?	0	1	2	3
Does food or liquid come out of your nose when you eat or drink?	0	1	2	3
Does chewed up food dribble from your mouth?	0	1	2	3
Do you feel you have too much saliva in your mouth: do you drool or have difficulty swallowing your saliva?	0	1	2	3
Do you swallow chewed up food several times before it goes down your throat?	0	1	2	3
Do you experience difficulty in swallowing solid food (i.e. do apples or crackers get stuck in your throat)?	0	1	2	3
Do you experience difficulty in swallowing pureed food?	0	1	2	3
While eating, do you feel as if a lump of food is stuck in your throat?	0	1	2	3
Do you cough while swallowing liquids?	0	1	2	3
Do you cough while swallowing solid foods?	0	1	2	3
Immediately after eating or drinking, do you experience a change in your voice, such as hoarseness or reduced voice?	0	1	2	3
Other than during meals, do you experience coughing or difficulty breathing as a result of saliva entering your windpipe?	0	1	2	3
Do you experience difficulty in breathing during meals?	0	1	2	3
Have you suffered from a respiratory infection (pneumonia, bronchitis) during the past year?	YES		NO	
	If Yes, which?			

Cutoff greater than/equal to 11 for abnormal.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_.

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_.