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Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_

**Eating Assessment Tool - 10 \***

*Instructions*: Circle the appropriate response. To what extent are the following scenarios problematic for you?

*0 = no problem, 4 = severe problem*

**Write a number**

1. My swallowing problem has caused me to lose weight.

2. My swallowing problem interferes with my ability to go out for meals.

3. Swallowing liquids takes extra effort.

4. Swallowing solids takes extra effort

5. Swallowing pills takes extra effort.

6. Swallowing is painful.

7. The pleasure of eating is affected by my swallowing.

8. When I swallow, food sticks in my throat.

9. I cough when I eat.

10. Swallowing is stressful.

|  |  |
| --- | --- |
| **PLEASE ADD UP YOUR TOTAL** |  |

\* Belafsky, P., Mouadeb, D., Ress, C., Pryor, J., Postma, G., Allen, J., & Leonard, R. (2008). Validity and reliability of the eating assessment tool (EAT-10), *Annals of Otology, Rhinology & Laryngology, 117*, 919-924.

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