Greenville ENT

Head and Neck Self Rating Form

Name/MRN: _____ DOB: _____ Today's date: _____

Please mark to indicate the treatment you are currently receiving: ___ Radiation ___Chemotherapy ___ N/A Week of treatment: _____

How much are you are eating and drinking by mouth?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

I am using my PEG for all nutrition-------I use my PEG sometimes--------I never use my PEG/don't have a PEG

Please indicate to what degree these situations have affected you in the <u>past week</u>: 0=not at all and 10=all of the time

Dry mouth

0 1 2 3 4 5 6 7 8 9 10

Mouth pain

0 1 2 3 4 5 6 7 8 9 10

Painful swallowing

0 1 2 3 4 5 6 7 8 9 10

Sore throat

0 1 2 3 4 5 6 7 8 9 10

Change in taste

0 1 2 3 4 5 6 7 8 9 10

Are you receiving Home Health therapy? Yes / No

<u>For SLP use only:</u>

Distress score: _____

Weight: stable/losing/gaining _____

# of supplements: _____

Types of food: _____

HEP completion: _____

Jaw ROM pre: _____ *post:* _____

DDK pre: _____ *post:* _____

Tongue score

pre post