

## EATING ASSESSMENT TOOL (EAT-10)

Date: \_\_\_\_\_

Name: \_\_\_\_\_ MR#: \_\_\_\_\_

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

Please briefly describe your swallowing problem.

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Please list any swallowing tests you have had, including where, when, and the results.

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To what extent are the following scenarios problematic for you?

Circle the appropriate response	0 = No problem 4 = Severe problem				
1. My swallowing problem has caused me to lose weight.	0	1	2	3	4
2. My swallowing problem interferes with my ability to go out for meals.	0	1	2	3	4
3. Swallowing liquids takes extra effort.	0	1	2	3	4
4. Swallowing solids takes extra effort.	0	1	2	3	4
5. Swallowing pills takes extra effort.	0	1	2	3	4
6. Swallowing is painful.	0	1	2	3	4
7. The pleasure of eating is affected by my swallowing.	0	1	2	3	4
8. When I swallow food sticks in my throat.	0	1	2	3	4
9. I cough when I eat.	0	1	2	3	4
10. Swallowing is stressful.	0	1	2	3	4
<b>Total EAT-10:</b>					