Eating Assessment Tool (EAT-10)

Date:_____

Name: _____MR#: _____

Height:_____Weight:_____

Please briefly describe your swallowing problem.

_____

_____

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

_____

_____

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
				Total EAT-10:	

Belafsky PC, Mouadeb DA, Rees CJ, Pryor JC, Postma GN, Allen J, and Leonard RJ. Validity and reliability of the Eating Assessment Tool (EAT-10). *Ann Otol Rhinol Laryngol* 117: 919-924, 2008.