Eating Assessment Tool (EAT-10)

Patient Information:
Name:
Height:
Weight:
Please briefly describe your swallowing problem:
Please list any swallowing tests you have had, including where, when, and the results:
Please review the following scenarios.
Choose an answer between **0 (no problem with swallowing)** and **4 (severe problem with swallowing)** to explain the severity of your swallowing problem in each scenario.

Questions	**0**	**1**	**2**	**3**	**4**
My swallowing problem has caused me to lose weight.					
My swallowing problem interferes with my ability to go out for meals.					
Swallowing liquids takes extra effort.					
Swallowing solids takes extra effort.					
Swallowing pills takes extra effort.					
Swallowing is painful.					
The pleasure of eating is affected by my swallowing.					
When I swallow, food sticks in my throat.					
I cough when I eat.					
Swallowing is stressful.					

EAT-10 Total:
Please add the numbers from your answers to the scenarios and enter the total here: