Name:

EAT-10 Instructions: To what extent are the following scenarios problematic for you? Please cross the appropriate responses.

0 = No Problem *4 = Severe Problem*

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

Total: ___________________________

BAI Instructions: Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY BUT IT DIDN'T BOTHER ME MUCH.	MODERATELY - IT WASN'T PLEASANT AT TIMES	SEVERELY – IT BOTHERED ME A LOT
NUMBNESS OR TINGLING	0	1	2	3
FEELING HOT	0	1	2	3
WOBBLINESS IN LEGS	0	1	2	3
UNABLE TO RELAX	0	1	2	3
FEAR OF WORST HAPPENING	0	1	2	3
DIZZY OR LIGHTHEADED	0	1	2	3
HEART POUNDING/RACING	0	1	2	3
UNSTEADY	0	1	2	3
TERRIFIED OR AFRAID	0	1	2	3
NERVOUS	0	1	2	3
FEELING OF CHOKING	0	1	2	3
HANDS TREMBLING	0	1	2	3
SHAKY / UNSTEADY	0	1	2	3
FEAR OF LOSING CONTROL	0	1	2	3
DIFFICULTY IN BREATHING	0	1	2	3
FEAR OF DYING	0	1	2	3
SCARED	0	1	2	3
INDIGESTION	0	1	2	3
FAINT / LIGHTHEADED	0	1	2	3
FACE FLUSHED	0	1	2	3
HOT/COLD SWEATS	0	1	2	3
Column sum				

RSI Instructions: These are statements that people have used to describe their acid reflux/heartburn symptoms. Please cross the appropriate responses.

0 = No Problem *5 = Severe Problem*

Hoarseness or a problem with your voice.	0	1	2	3	4	5
Clearing your throat.	0	1	2	3	4	5
Excess throat mucus.	0	1	2	3	4	5
Difficulty swallowing food, liquids or pills.	0	1	2	3	4	5
Coughing after eating or after lying down.	0	1	2	3	4	5
Breathing difficulties or choking episodes.	0	1	2	3	4	5
Troublesome or annoying cough.	0	1	2	3	4	5
Sensations of something sticking in your throat or a lump in your throat.	0	1	2	3	4	5
Heartburn, chest pain, indigestion, or stomach acid coming up.	0	1	2	3	4	5

Total: ______________________________

VHI-10 Instructions: These are statements that people have used to describe their voices and the effects of their voice issues have on their lives. Please cross the response that indicates how frequently you had the following experiences in the **last 4 weeks**.

0 = Never *1 = Almost Never* *2 = Sometimes* *3 = Almost Always* *4 = Always*

My voice makes it difficult for people to hear me.	0	1	2	3	4
People have difficulty understanding me in a noisy room.	0	1	2	3	4
My voice difficulties restrict personal and social life.	0	1	2	3	4
I feel left out of conversations because of my voice.	0	1	2	3	4
My voice problem causes me to lose income.	0	1	2	3	4
I feel as though I have to strain to produce voice.	0	1	2	3	4
The clarity of my voice is unpredictable.	0	1	2	3	4
My voice problem upsets me.	0	1	2	3	4
My voice makes me feel handicapped.	0	1	2	3	4
People ask "what's wrong with your voice?"	0	1	2	3	4

Total: ______________________________

DI Instructions: These are statements that people have used to describe their shortness of breath. Please circle the response that indicates how frequently you had the following experience. You may circle zero for all questions if you do not have shortness of breath.

0 = Never *1 = Almost Never* *2 = Sometimes* *3 = Almost Always* *4 = Always*

I have trouble getting air in.	0	1	2	3	4
I feel tightness in my throat when I am having my breathing problem	0	1	2	3	4
It takes more effort to breath than it used to.	0	1	2	3	4
Changes in weather affect my breathing problem	0	1	2	3	4
My breathing gets worse with stress	0	1	2	3	4

I make sound/noise breathing in	0	1	2	3	4
I have to strain to breathe	0	1	2	3	4
My shortness of breath gets worse with exercise or physical activity	0	1	2	3	4
My breathing problem makes me feel stressed	0	1	2	3	4
My breathing problem causes me to restrict my personal and social life	0	1	2	3	4

Beck's Depression Inventory: Please carefully read each item in the list. Indicate how do you feel, by circling the number in the corresponding space in the column next to each symptom.

1. I do not feel sad.
2. I feel sad
3. I am sad all the time and I can't snap out of it.
4. I am so sad and unhappy that I can't stand it.

1. I am not particularly discouraged about the future.
2. I feel discouraged about the future.
3. I feel I have nothing to look forward to.
4. I feel the future is hopeless and that things cannot improve.

1. I do not feel like a failure.
2. I feel I have failed more than the average person.
3. As I look back on my life, all I can see is a lot of failures.
4. I feel I am a complete failure as a person.

1. I get as much satisfaction out of things as I used to.
2. I don't enjoy things the way I used to.
3. I don't get real satisfaction out of anything anymore.
4. I am dissatisfied or bored with everything.

1. I don't feel particularly guilty
2. I feel guilty a good part of the time.
3. I feel quite guilty most of the time.
4. I feel guilty all of the time.

1. I don't feel I am being punished.
2. I feel I may be punished.
3. I expect to be punished.
4. I feel I am being punished.

1. I don't feel disappointed in myself.
2. I am disappointed in myself.
3. I am disgusted with myself.
4. I hate myself.

1. I don't feel I am any worse than anybody else.
2. I am critical of myself for my weaknesses or mistakes.
3. I blame myself all the time for my faults.
4. I blame myself for everything bad that happens.

1. I don't have any thoughts of killing myself.
2. I have thoughts of killing myself, but I would not carry them out.
3. I would like to kill myself.
4. I would kill myself if I had the chance.

1. I don't cry any more than usual.
2. I cry more now than I used to.
3. I cry all the time now.
4. I used to be able to cry, but now I can't cry even though I want to.

1. I am no more irritated by things than I ever was.
2. I am slightly more irritated now than usual.
3. I am quite annoyed or irritated a good deal of the time.
4. I feel irritated all the time.

1. I have not lost interest in other people.
2. I am less interested in other people than I used to be.
3. I have lost most of my interest in other people.
4. I have lost all of my interest in other people.

1. I make decisions about as well as I ever could.
2. I put off making decisions more than I used to.
3. I have greater difficulty in making decisions more than I used to.
4. I can't make decisions at all anymore.

1. I don´t feel like I look any worse than I used to
2. I am worried that I am looking old or unattractive.
3. I feel there are many permanent changes in my appearance that make me look unattractive
4. I believe that I look ugly.

1. I can work about as well as before.
2. It takes an extra effort to get started at doing something.
3. I have to push myself very hard to do anything.
4. I can't do any work at all.

1. I can sleep as well as usual.
2. I don't sleep as well as I used to.
3. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
4. I wake up several hours earlier than I used to and cannot get back to sleep.

1. I don't get more tired than usual.
2. I get tired more easily than I used to.
3. I get tired from doing almost anything.
4. I am too tired to do anything.

1. My appetite is no worse than usual.
2. My appetite is not as good as it used to be.
3. My appetite is much worse now.
4. I have no appetite at all anymore.

1. I haven't lost much weight, if any, lately.
2. I have lost more than five pounds.
3. I have lost more than ten pounds.
4. I have lost more than fifteen pounds.

1. I am no more worried about my health than usual.
2. I am worried about physical problems like aches, pains, upset stomach, or constipation.
3. I am very worried about physical problems and it's hard to think of much else.
4. I am so worried about my physical problems that I cannot think of anything else.

1. I have not noticed any recent change in my interest in sex.

2. I am less interested in sex than I used to be.
3. I have almost no interest in sex.
4. I have lost interest in sex completely.

QOL (QUALITY OF LIFE INDEX©) Instructions: Please circle the number that explains how you have been IN THE PAST TWO MONTHS. Please say "In the past two months" ahead of each question as you think about the answer. If the question does not apply to you, please circle not applicable. There are no right or wrong answers.

NEVER | VERY RARELY | RARELY | SOMETIMES | USUALLY | VERY FRECUENTLY | ALWAYS

IN THE PAST TWO MONTHS:

1. Have you been afraid to eat outside because of food causing throat symptoms?
   NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

2. Have you felt angry as a result of your throat problem?
   NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

3. Did you need to go suddenly when you had a throat movement?
   NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

4. Did your throat symptoms interfere with your relationship with your children and/or partner?
   NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

5. Did you avoid foods that you like because you were afraid that they might cause throat symptoms?
   NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

6. Did your throat symptoms interfere with being able to do well at work/school/usual daily activities?
   NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

7. Have you felt tearful os discouraged as a result of your throat problem?
   NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

8. Did you feel that your family/friends thought your symptoms were not real?
   NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

9. How often, while participating in leisure or sport activities did you have to stop because of your throat symptoms?
   NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

10. Have you felt worried or anxious about never feeling any better?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

11. Did you miss work/school/usual daily activities because of your throat problem?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

12. Did your throat symptoms interfere with being able to concentrate?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

13. Have you felt alone or isolated from your family because of your throat symptoms?

NEVER 0 1 2 3 4 5 6 ALWAYS NOT APPLICABLE

14. Were you embarrassed because of your throat symptoms?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

15. Were you troubled by pain in your abdomen?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

16. Were you afraid that your throat symptoms were getting worse?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

17. Were you troubled by throat movements that were hard/difficult to pass?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

18. Did you check your diet from the previous day trying to find food that might cause throat symptoms?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

19. Did you avoid traveling due to worry about throat symptoms?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

20. Did your throat problems shorten the length of time you could work each day?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

21. Did your throat symptoms keep you from sleeping soundly during the night?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

22. Were you troubled by loose throat movement?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

23. Did your throat condition interfere with having sexual relations?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

24. Has being bloated troubled you?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

25. Did your throat symptoms interfere with your enjoyment of leisure or sport activities?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

26. Was passing large amount of gas a problem?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

27. Were you concerned that your symptoms may be due to cancer?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

28. Have you had to delay or cancel going out socially because of your throat problem?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

29. Were you tired in the morning because of your throat symptoms?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

30. Did your throat symptoms interfere with your desire to have sexual relations with your partner?
    NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

31. Has feeling that you need to go to the bathroom even though your bowels are empty troubled you?

NEVER 0 1 2 3 4 5 6 ALWAYS NOT APPLICABLE

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32. Did you feel that your doctor/health professionals did not believe that your throat symptoms are real?

NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

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33. How often do you immediately need to find where washrooms are when you are in a new place?

NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

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34. Did you avoid planning activities ahead of time because you were unsure of how your throat symptoms would be?

NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

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35. Has accidental soiling of your underwear troubled you?

NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**

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36. Were you late for or did you delay work/school/usual daily activities because of your throat symptoms?

NEVER 0 1 2 3 4 5 **6 ALWAYS** **NOT APPLICABLE**