Drooling Measures Form

Date: / /

Name of child: _____

Form completed by: _____

Relationship to person: _____

1. Is the person currently on medication to reduce drooling?

❑ No ❑ Yes

If yes, please give name and amount taken during the last week:

_____

_____

2. Has the person been well over the past week?

❑ No ❑ Yes

If no, please give details of illness: _____

_____

3. Rating scale. Please discuss these with anyone who knows the person well and circle the number which best reflects the severity and frequency of drooling over the past week:

Frequency

1 No drooling – dry
2 Occasional drooling – not every day
3 Frequent drooling - every day but not all day
4 Constant drooling – always wet

Severity

1 Dry – never drools
2 Mild – only the lips are wet
3 Moderate – wet on the lips and the chin
4 Severe – drools to the extent the clothes &/or objects get wet
5 Profuse – clothing, hands and objects become very wet

4. On an average day over the past week when the person is at home:

Number of bib changes per day: _____

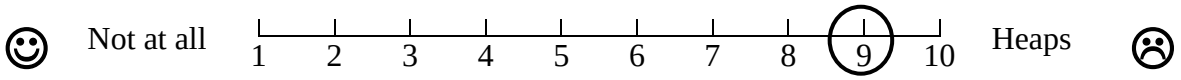
Number of clothes changes per day: _____

Please turn over page.

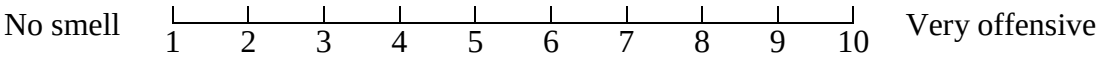
For the questions 5-14, please draw a circle around the number between 1 and 10 that indicates the extent to which each question about drooling has affected you over the past week.

For example:

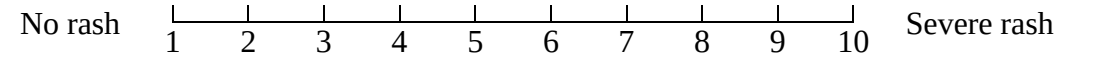
How much do television advertisements annoy you?



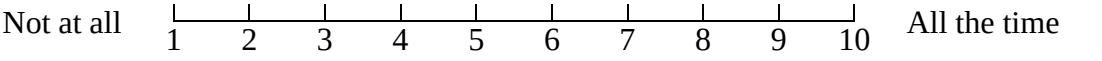
5. How offensive was the smell of the saliva?



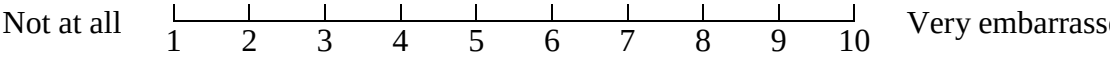
6. How much of a problem has there been with skin rashes on the chin and around mouth?



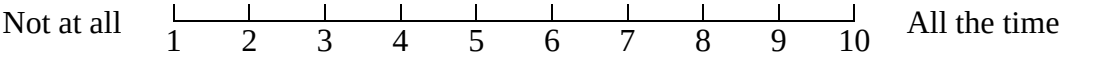
7. How frequently did the person's mouth need wiping?



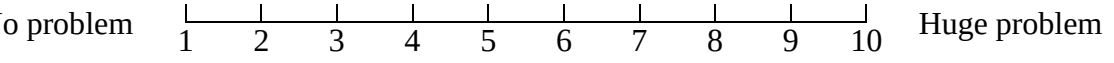
8. How embarrassed does the person seem to be about his/her dribbling?



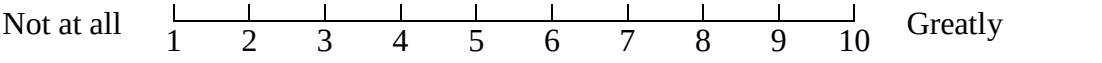
9. How much do you have to wipe or clean saliva from household items eg toys, furniture, computers etc?



10. How much of a problem does the person have with coughing or choking on saliva?



11. To what extent does the person's drooling affect <u>his or her</u> life?



12. Was the person on other medication over the past week?

❑ Yes ❑ No ❑ Unsure

IF YES, please include names of medication below:

13. Has the person had saliva control surgery?

❑ **NO ➔ NO MORE QUESTIONS** ❑ **YES** → Go to Question 14

14. How worthwhile do you believe the person's saliva surgery has been?

Not at all 1 2 3 4 5 6 7 8 9 10 Extremely

1 2 3 4 5 6 7 8 9 10

Comments:

Thank you for completing this questionnaire.