PLEASE PUT YOUR NAME ON FORMS

Name :

Date completed :

RSI form

Within the last month, how did the following problems affect you?

0 = No Problem, 5 = Significant 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 or postnasal drip	0	1	2	3	4	5
Difficulty swallowing food, liquids or pills	0	1	2	3	4	5
Coughing after you eat or lie 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 = _____