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?

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

5. How offensive was the smell of the saliva?

No smell 1 2 3 4 5 6 7 8 9 Very offensive 10

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

No rash 1 2 3 4 5 6 7 8 9 Severe rash 10

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

Not at all 1 2 3 4 5 6 7 8 9 All the time 10

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

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

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

Not at all 1 2 3 4 5 6 7 8 9 All the time 10

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

No problem 1 2 3 4 5 6 7 8 9 Huge problem 10

11. To what extent does the person’s drooling affect his or her life?

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

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.

OR-FM-HS-SM-78(11-10-09)