**Title of Video: Educational Video for Individuals with Dysphagia**
**Patient Exercise Form**

**Patient Name:** **Clinician Name:**

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| **Name of Exercise** | | | | | | | |
| **Time of Day** | | | | | | | |
| **Number of Repetitions** | | | | | | | |
| | | | | | | | |
| **Name of Exercise** | | | | | | | |
| **Time of Day** | | | | | | | |
| **Number of Repetitions** | | | | | | | |
| | | | | | | | |
| **Name of Exercise** | | | | | | | |
| **Time of Day** | | | | | | | |
| **Number of Repetitions** | | | | | | | |
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| **Name of Exercise** | | | | | | | |
| **Time of Day** | | | | | | | |
| **Number of Repetitions** | | | | | | | |
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| **Name of Exercise** | | | | | | | |
| **Time of Day** | | | | | | | |
| **Number of Repetitions** | | | | | | | |
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| **Name of Exercise** | | | | | | | |
| **Time of Day** | | | | | | | |
| **Number of Repetitions** | | | | | | | |
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| **Name of Exercise** | | | | | | | |
| **Time of Day** | | | | | | | |
| **Number of Repetitions** | | | | | | | |
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**Overall Comments:**

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