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ADULT VOICE CASE HISTORY

Name:_____ Date of Birth:_____

Address:_____City: _____State:_____Zip:_____

Phone Home: _____ Work: _____ Cell: _____

Referring physician: _____ Phone: _____

Pertinent Medical Diagnosis: _____

Primary Language: _____ Other Language(s) spoken: _____

Reason for referral: _____

_____

What motivated you to seek advice or help regarding your voice? _____

_____

_____

HISTORY OF THE PROBLEM

Describe the existing voice problem: _____

_____

_____

When did you first notice the problem? _____

_____

How long has it been present? _____ Did is start: gradually _____ or suddenly _____

Do you know what caused it?_____ If so, explain: _____

_____

Have you been seen by an ear, nose, and throat physician? Yes___No___Date Seen:_____

Results/diagnosis: _____

Recommendations: _____

Estimated severity of the problem: Mild_____ Moderate_____ Severe_____

Have any other individuals recognized your problem (friends, family, etc.)? _____

_____

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How would you describe your voice? (check items that apply)

Harsh____ Hoarse____ Nasal____ Breathy____ Monotonous_____

Voice pitch too high ____ Voice pitch too low ____ Voice too loud ____

Voice too soft ____ Frequent pitch break ____ Infrequent pitch break ____

Difficulty controlling voice ____ Voice pitch quivers ____ Vocal intensity quavers ____

Other:_____

Do you think that your breathing has anything to do with your voice problem? Yes____ No____

Have you ever been a mouth breather (breathing only through you r mouth)? Yes____ No____

If so, when? _____

How has this voice problem affected you? _____

_____

VARIATION OF THE PROBLEM

List 3 situations in which the voice problem is **least** troublesome:

1._____

2._____

3._____

List 3 situations in which the voice problem is **most** troublesome:

1._____

2._____

3._____

What happens to your voice when you get:

Excited? _____

Anxious? _____

Angry? _____

Depressed? _____

Other? _____

Do you have any pain/tightness in the neck, face or ears? Yes_____ No_____

Describe the nature of pain/tightness: _____

_____

Do you have throat pain at any of these times:

Morning? _____

Evening? _____

After talking for extended periods of time? _____

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When is your voice better? (check items that apply)

In the morning: _____

Midday: _____

Evening: _____

No change during the day:_____

How often do you "lose" your voice?_____

Have you ever received any prior speech, voice or hearing evaluations? _____

Have you ever received therapy for speech or voice? _____

Did prior evaluation or therapy relate to the current problem: _____

What was the nature of the evaluation and/or therapy? _____

_____

How effective has prior therapy been in helping with the problem? _____

_____

_____

FAMLY AND ENVIRONMENTAL INFORMATION

Please list names/ages/relationship of each family member living in the home:

_____

_____

Description of vocal and laryngeal use (daily use and/or abuse):
(check appropriate column)

	OFTEN	SOMETIMES	NEVER
Talking in a noisy environment			
Excessive speaking			
Shouting			
Screaming			
Yelling			
Coughing			
Clearing Throat			
Sneezing			
Singing			
Voice impersonations			
Cheering or Cheerleading			
Talking on phone			
Caffeine consumption			

Any singing experience? Yes____ No____

If yes, please describe:_____

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Occupation:_____

Describe how you use your voice during the work day:_____

_____

Are you under stress? Yes____ No____

Is there a family history of emotional difficulties?_____

Are there pets in the home?_____

Does anyone in the immediate family have a similar voice problem? Yes____ No____

If so, who?_____

HEALTH HISTORY

Describe your current health:_____

Is there a **history** of: *(please check under Yes or No column for each health issue below)*

	Yes	No		Yes	No
Allergies	____	____	Numbness	____	____
Sinus Infection	___	____	Paralysis/Paresis	___	____
Asthma	____	____	Broken Nose	____	____
Incoordination Of face or tongue Muscles	___	___	Bronchitis	___	___
			Mouth-Breathing	___	____
Influenza	___	____	Chronic Laryngitis	___	____
Chronic Colds	___	____	Physical defect	____	____
Pneumonia	___	____	Snoring	___	____
Cleft Palate	___	____	TMJ Disorder	____	____
Tonsillectomy	___	____	Hiatal Hernia	___	____
Reflux	___	____	Hearing Problem	___	____
Swallowing Difficulty	___	____	Anxiety or Depression	___	___
Tremor/Twitching	___	____	Glandular imbalance	___	____
Ulcers	____	____	Adenoidectomy	___	____
Heartburn	___	____	Post Nasal Drip	____	____
Hormone therapy	___	____	Chemical Exposure	____	____
Whooping Cough	___	____	Hypertension	____	___
Other_____			Prescription medication	___-	___

If the answer to any of the above items is "Yes", please describe: _____

_____

Daily/Weekly alcohol consumption:_____

Cigarette Use: Yes ____ No ____ If yes, how many per day? _____

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List periods of hospitalization or medical treatment:

Hospital: Date: Reason:

1. _____

2. _____

3. _____

List all surgical procedures (related or unrelated to the **voice** problem):_____

_____

List all prescription and non-prescription medication used over the past year (name the type if you cannot remember the brand name, i.e. aspirin, allergy pills).

_____

_____

Have you ever had a trauma to the head or neck? Yes_____ No_____ If yes, please describe:

_____

Have you ever had a neurological examination? Yes___No____ If so, by whom, when, and where?

_____

_____

How do you feel this clinic can assist you? _____

_____

_____

_____

Additional comments or questions? _____

_____

_____

_____

_____

_____

Signature **Date**

Printed Name **Relationship to Client**