

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 it 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.)? _____

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 your 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? _____

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? _____

FAMILY 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: _____

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			Bronchitis	___	___
Of face or tongue Muscles	___	___	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? _____

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