Chris Byers, MA, CCC-SLP
28348 Roadside Drive, Suite 201
Agoura Hills, CA 91301
818.419.1123

PEDIATRIC VOICE CASE HISTORY

Name:_____ Date of Birth:_____

Address:_____City: _____State:_____Zip:_____

Parent Phone Home: _____ Work: _____ Cell: _____

Referring physician: _____ Phone: _____

Pertinent Medical Diagnosis: _____

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

Referred by: _____

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

_____

_____

FAMILY HISTORY

Mother's Name: _____ Occupation: _____
Address (if different) _____
Father's Name: _____ Occupation: _____
Address (if different) _____

Please list all family members living in the home:

Name	Age	Sex	Grade	Speech, Hearing or Voice Problems

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: _____

_____

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Has your child been seen by an ear, nose, and throat physician? Yes___No___Date Seen:_____

Name of ENT physician: _____

Results/diagnosis: _____

Recommendations: _____

Have any other individuals recognized his/her problem (friends, family, etc.)? _____

How would you describe his/her 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 his/her breathing has anything to do with his/her voice problem?

(e.g., asthma, shortness of breath, takes too few pauses/breaths when speaking) Yes ___ No ____

Has he/she ever been a mouth breather (breathing only through his/her mouth)? Yes ___ No ____

If so, when? _____

Is your child aware of his/her voice problem? _____

How has this voice problem affected him/her? _____

VARIATION OF THE PROBLEM

List 3 situations or times of day in which the voice problem is **least** troublesome:

1._____

2._____

3._____

List 3 situations or times of day in which the voice problem is **most** troublesome:

1._____

2._____

3._____

What happens to his/her voice when he/she gets:

Excited? _____

Anxious? _____

Angry? _____

Depressed? _____

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Does he/she complain of any pain in the neck, face or ears? Yes_____ No_____

Describe the nature of the pain _____

Does he/she complain of throat pain at any of these times:

Morning? _____

Evening? _____

After talking for extended periods of time? _____

Is his/her voice better? (check items that apply)

In the morning: _____

Midday: _____

Evening: _____

No change during the day:_____

How often does he/she "lose" his/her voice?_____

Has he/she ever received any prior speech, voice or hearing evaluations? _____

Has he/she ever received therapy for speech or voice? _____

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

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

ENVIRONMENTAL INFORMATION

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			
Whispering			
Caffeine consumption			

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Any singing experience? Yes____ No____

If yes, please describe:_____

Is he/she exposed to second hand smoke? Yes ____ No ____

Is he/she 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?_____

Describe your child's personality: _____

HEALTH HISTORY

Describe your child's 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	___-	___

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

_____

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)._____

_____

_____

Has your child ever had a trauma to the head or neck? Yes ___ No_____ If yes, please describe:

_____

Has your child ever had a neurological examination? Yes___No
f so, by whom, when, and where?

_____

_____

How do you feel this therapist can assist your child? _____

_____

_____

_____

Additional comments or questions? _____

_____

_____

_____

_____

_____

_____ _____

Signature **Date**

_____ _____

Printed Name **Relationship to Client**