

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:

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Grade</u>	<u>Speech, Hearing or Voice Problems</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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: _____

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			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	_____	_____

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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 ___
If 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