Speech-Language Institute
Case History: Voice Addendum

Please complete and return prior to the first appointment.

Fax: 623-806-7708 | 5815 W. Utopia Road Glendale, AZ 85308

Client Information				*Date Completed:*
Name:				**Date of Birth:**
	First (Preferred name)	*Middle Initial*	*Last*	

Voice Concerns	
☐	**Voice sounds harsh/hoarse**
☐	**Change in pitch/vocal range**
☐	**Breathy voice**
☐	**Pain/discomfort with speaking**
☐	**"Running out of air" when speaking**
☐	**"I can't get enough air."**
☐	**Vocal fatigue/increased effort to talk**
☐	**Unable to initiate a voice**
☐	**Difficulty coordinating breathing with speech**
☐	**Feeling a "lump" in the throat**
☐	**Feeling of throat or chest tightness**
☐	**Chronic cough**
☐	**Speaking valve use**
☐	**Other:**

Description of Concern:

Do your symptoms…

☐	**Occur during sleep/wake you up from sleeping?**
☐	**Occur when you aren't talking?**
☐	**Occur at rest?**
☐	**Seem to be stress-induced?**
☐	**Limit your activities?**
☐	**Affect your ability to do your work?**
☐	**Affect your ability to complete activities you enjoy?**

Voice History

When did your voice symptoms begin?

Were other medical or life events occurring at that time?

Have symptoms ☐ improved? ☐ worsened? ☐ remained consistent?

Please explain:

Did the symptoms begin ☐ gradually? Or ☐ suddenly?

Are symptoms worse during certain times of day? ☐Yes ☐ No

If yes, please describe:

Are symptoms worse in certain environments? ☐Yes ☐ No

If yes, please describe:

Have you ever had a voice evaluation/screening? ☐Yes ☐ No

If yes, where and when?

What were the results?

Have you ever had a study that visualized your vocal folds with an oral or nasal scope? ☐Yes ☐ No

If yes, where and when?

What were the results?

Have you ever been enrolled in voice therapy, or are you currently participating in voice therapy? ☐Yes ☐ No

If so, where?

How long?

Please describe services and progress:

Pertinent Medical History

Do you have a history of acid reflux/GERD? ☐Yes ☐ No

If so, what sorts of treatments are you currently using?

Do you feel your reflux is well managed?

Do you still have symptoms?

Have you ever/do you have cancer of the head, neck, or throat? ☐Yes ☐ No

If so, please describe its location:

Is it in remission?

When and how was/is it treated (e.g. surgery, radiation)?

Do you have asthma or other respiratory conditions? ☐Yes ☐ No

If so, please describe:

Do you have a history of COPD or other respiratory disorders? ☐Yes ☐ No

If so, would you consider your COPD to be worsening? ☐Yes ☐ No

Have you had any recent surgeries/procedures with general anesthesia? ☐Yes ☐ No

Voice Use

In your job, do you speak extensively (e.g. teacher, clergy, attorney)? ☐Yes ☐ No

Please answer the following questions using this scale: 0 = none, 1 = less than average, 2 = average, 3 = more than average.

Do you scream (not necessarily in anger, for example, at a sporting event or while working in a noisy environment)?	**☐ 0 ☐ 1 ☐ 2 ☐ 3**
Do you raise your voice (e.g. parenting, calling from room to room, etc.)?	**☐ 0 ☐ 1 ☐ 2 ☐ 3**
Do you talk for long periods of time without a break (teacher, singer)?	**☐ 0 ☐ 1 ☐ 2 ☐ 3**
Are you a talker?	**☐ 0 ☐ 1 ☐ 2 ☐ 3**
Do you clear your throat?	**☐ 0 ☐ 1 ☐ 2 ☐ 3**
Do you cough?	**☐ 0 ☐ 1 ☐ 2 ☐ 3**
Do you sing? (If yes, please explain)	**☐ 0 ☐ 1 ☐ 2 ☐ 3**
How often do you use the telephone?	**☐ 0 ☐ 1 ☐ 2 ☐ 3**
Do you do impersonations, character voices or unusual sound effects? If yes, please explain:	**☐ 0 ☐ 1 ☐ 2 ☐ 3**

Vocal Hygiene

Please list how much of the following you drink in ounces per day. 1 cup/glass = 8 oz.
Water____ Coffee____ Tea____ Soda____ Energy drinks____ Milk____
Juice____ Sports drinks____ Other (please specify)_____

How often do you drink alcoholic beverages (daily, weekly, rarely, never, etc.)?_____
Amount consumed in ounces: Beer____ Wine____ Liquor____

Are you currently using tobacco products? ☐Yes ☐ No
If yes, what type?
How much (packs/cans/etc.) per day?
How long have you been using tobacco?

Have you used tobacco products in the past? ☐Yes ☐ No
If yes, what type?
How much (packs/cans/etc.) per day?
How long did you use tobacco?
When did you stop?

Are you exposed to secondhand smoke? ☐Yes ☐ No
If yes, please explain:
Do you use products containing menthol? ☐Yes ☐ No
If yes, please list:
Do you take Vitamin C supplements? ☐Yes ☐ No
If yes, please list amount (mg) per day.
Do you use recreational drugs? ☐Yes ☐ No
If yes, please list type/amount/frequency.

Additional Swallowing Concerns