1527 Brown St. Suite A-1
El Paso, TX., 79902
Tel: 915-600-2069
Fax: 915-500-1875
WWW.EPSLSE.COM

El Paso Speech & Language
Service Excellence, PLLC

# 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? _____

_____

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 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?

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 is 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 | ☐ | ☐ | Chronic Rhinitis | ☐ | ☐ |
| Cleft Palate | ☐ | ☐ | Poliomyelitis | ☐ | ☐ |
| Ear Disease | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Scarlet Fever | ☐ | ☐ | Hearing Problem | ☐ | ☐ |
| Typhoid Fever | ☐ | ☐ | Psychological Counseling | ☐ | ☐ |
| Tremor/Twitching | ☐ | ☐ | Glandular imbalance | ☐ | ☐ |
| Ulcers | ☐ | ☐ | Hyperthyroidism | ☐ | ☐ |
| Visual Problem | ☐ | ☐ | Hypothyroidism | ☐ | ☐ |
| Hormone therapy | ☐ | ☐ | Heart Trouble | ☐ | ☐ |
| 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** **Date**