Goepfert Speech Associates, LLC

Voice History-Adult

Identifying Information Date: _____

Name: _____ D.O.B: _____ Age: _____

Address: _____

Phone (primary): _____ (other): _____

Physician: _____ Referral Source: _____

Marital Status: S /M /D /W Spouse: _____ Age: _____

Children: Name _____ Age: _____

Name _____ Age: _____

Name _____ Age: _____

Name _____ Age: _____

Employment History (Most Recent) Place, Date, Position

1._____

2._____

3._____

4. _____

History of the Problem Describe the existing voice problem: _____

_____

_____

When did it start occurring? _____

What were the circumstances? _____

How long has it been present? _____

Do you know why it is present? _____ If so, explain _____

_____

Have you been seen by an Ear, Nose, and Throat Physician? ☐ Yes ☐ No

Date seen: _____ Physician: _____

Results/Diagnosis: _____

Recommendations: _____

Estimate severity of problem: ____ Mild ____ Moderate ____ Severe

What other individuals recognize your problem, and how do they react? _____

_____

Voice History-Adult

How would you describe your voice? (Check all items that apply)

☐ Voice pitch too high ☐ Voice pitch too low ☐ Voice too loud ☐ Voice too soft

☐ Frequent pitch breaks ☐ Infrequent pitch breaks ☐

☐ Harsh ☐ Hoarse ☐ Nasal ☐ Breathy ☐ Monotonous ☐ Difficulty controlling voice

☐ Vocal pitch quavers ☐ Vocal intensity quavers ☐ Other (explain) _____

Do you think your breathing has anything to do with your voice problem? ☐ Yes ☐ No

Have you ever been a mouth breather? _____ If so, when does it occur? _____

How has this voice problem affected you? _____

_____

Variation of the problem:
List 5 situations in which your voice problem is <u>least</u> troublesome:

1._____ 2._____

3._____ 4._____

5._____

List 5 situations in which your voice problem is <u>most</u> troublesome:

1._____ 2._____

3._____ 4._____

5._____

What happens to your voice when you get:

Excited? _____

Anxious? _____

Angry? _____

Depressed? _____

Other _____

Do you have any pain in your neck or ears? ☐ YES ☐ NO If yes, please describe_____

_____

Does your throat hurt during any of these times:

☐ Morning ☐ Evening ☐ After working ☐ After talking for extended periods of time

Voice History-Adult

Description of vocal and laryngeal use (Daily use and/or abuse): Check all appropriate

Description	Often	Sometimes	Never
Talking in a noisy environment			
Excessive speaking			
Shouting (eg. Hollering)			
Screaming (eg. Shrill piercing sound)			
Yelling and/or crying			
Coughing			
Clearing throat			
Sneezing			
Singing			
Voice Impersonation			
Yodeling			
Cheering or cheerleading			

Any singing experience? ☐ YES ☐ NO If yes, please describe:

_____

Are you under stress? ☐ YES ☐ NO If yes, check the areas that apply:

☐ Marital ☐ Professional ☐ Other _____

Which of the following adjectives best describe your marital relationship? ☐ Peaceful ☐ Stressful

Is there a family history of emotional difficulties? ☐ YES ☐ NO

Does anyone in the immediate family or close associates have a similar voice problem? ☐ YES ☐ NO

If yes, who? _____

How has the voice problem affected your job status? _____

_____

Is your job basically ☐ Stressful? ☐ Peaceful?

How has this voice problem affected your social relationships? _____

_____

Voice History-Adult

When is your voice better? (Check all that apply)

☐ Morning ☐ Mid-day ☐ Evening ☐ No change

Did you refer yourself to the speech and hearing clinic? ☐ YES ☐ NO

If no, who referred you? _____

Do you feel the referral to this clinic is appropriate and reasonable? ☐ YES ☐ NO

Have you ever received any prior speech, voice or hearing evaluation? ☐ YES ☐ NO

Have you ever received any prior speech, voice or hearing therapy? ☐ YES ☐ NO

Agency: _____

Address: _____

Dates: _____

Did the prior evaluation or therapy relate to the present problem? ☐ YES ☐ NO

If yes, how? _____

What was the nature of the evaluation and therapy? _____

_____

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

_____

Have you, yourself, tried to do anything to help correct your problem? ☐ YES ☐ NO

If yes, please explain _____

Was it successful? ☐ YES ☐ NO

Family and Environmental Information

Do other members of the family have voice or speech problems? ☐ YES ☐ NO

If yes, describe the nature of the problem and relation of person to you in each case: _____

_____

_____

_____

Health History

Describe your present health: _____

_____

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History of (Check all that apply):

Allergies		Glandular Imbalance	
Sinus Infection		Thyroiditis	
Asthma		Hyperthyroidism	
Broken nose		Hypothyroidism	
Bronchitis		Hormone Therapy	
Chronic Colds		Hypertension	
Chronic Rhinitis (runny nose)		Paralysis/Paresis	
Chronic Laryngitis		Mouth Breathing	
Cleft Palate		Tremors/Twitching	
Hearing/Ear Problems		Ulcers	
Emotional Difficulty		Other _____	
Chronic Indigestion		Other_____	
Smoking		How much per day?	
Drinking		How much per day?	

Please give details of all checked items above: _____

_____

_____

Have you experienced any of these symptoms during or after speaking? (Check all that apply)

Tired Voice		Loss of Voice	
Neck Aches and Pains		Pain at the Back of Neck	
Pressure at Sternum		Dry Throat	
Neck Muscle Cording/Tightening		Hoarseness	
Lump in Throat		Progressive Vocal Fatigue following use	
Tickling, Tearing, or Burning Sensation in the Throat		Back Neck Tension	
Throat Clearing		Voice Comes and Goes over a period of time	
Coughing		Breathing Difficulty	
Repeated Sore Throats		Swallowing Difficulty	
Voice Breaks and Skips		Headaches	

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List Periods of Hospitalization or Medical Treatment:

Hospital	Date	Reason

List all Surgical Procedures (related or unrelated to the voice problem):

Procedure	Date	Reason

List all Prescription and Non-Prescription Medication Used Over the Past Year:

Medication	Dose	How often?

Have you ever had a trauma to the head or neck? ☐ YES ☐ NO

Have you ever had a neurological examination? ☐ YES ☐ NO

If yes, by whom, when and where? _____

_____

How do you feel this clinic can assist you? _____

_____

_____

List any additional sources of information which may be helpful to us in assisting with your problem:

_____

_____

List any additional comments or questions: _____

_____

_____