

**VOICE CASE HISTORY  
 ADULT FORM (16 years and over)**

Instructions: Please complete the following information to the best of your ability and as completely as possible. The information contained in this form will be used by our diagnostic team to develop a plan and generate a report. If you need more space, please feel free to use the back of the form.

**General Demographic Information:**

Date:			
Client's Name		Client's Preferred Name	
Client's Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say	Client's DOB	
Client's Race	<input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Indigenous <input type="checkbox"/> Hispanic <input type="checkbox"/> Other_____		
Person Completing Form:		Relationship to client:	
Primary Language	Client in the home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other_____	Parent/Caregiver in the home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other_____	
	Client in the community: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other_____	Parent/Caregiver in the community: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other_____	
Address:	Address 1:		
	Address 2:		
Phone Number(s):	Primary Contact Number:		
	<input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Other_____		
	Secondary Contact Number:		
	<input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Other_____		
<b>Please complete the guardian section if client is 18 years of age or under</b>			
Mother's Name		Father's Name	
Mother's Occupation		Father's Occupation	
Mother's Email		Father's Email	
Primary Guardian Name (if different from parents)		Referred by:	
Individuals living in the home and age	Client primarily lives: <input type="checkbox"/> With Spouse <input type="checkbox"/> With Partner <input type="checkbox"/> Independently/Roommate <input type="checkbox"/> With both parents <input type="checkbox"/> With mother <input type="checkbox"/> With father <input type="checkbox"/> With guardian <input type="checkbox"/> With Grandparents <input type="checkbox"/> With Foster Parent/Guardian Name: _____ Age: _____ Name: _____ Age: _____ Name: _____ Age: _____ Name: _____ Age: _____		

Name and address of Primary Care Physician	
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**Physical-Medical History:**

History of Illness (check all that apply)	<input type="checkbox"/> Heart Condition <input type="checkbox"/> Visual Difficulties <input type="checkbox"/> Hearing difficulties <input type="checkbox"/> ADHD <input type="checkbox"/> High Fever <input type="checkbox"/> Influenza <input type="checkbox"/> Tonsillitis <input type="checkbox"/> PE tubes <input type="checkbox"/> Genetic Disorder <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Down's Syndrome <input type="checkbox"/> Autism <input type="checkbox"/> ODD <input type="checkbox"/> Reflux/GERD	<input type="checkbox"/> COVID <input type="checkbox"/> Seizure Disorder/Epilepsy <input type="checkbox"/> Frequent colds <input type="checkbox"/> Frequent ear infections <input type="checkbox"/> Allergies <input type="checkbox"/> Frequent Strep <input type="checkbox"/> Tonsillectomy/Adenoidectomy <input type="checkbox"/> Diabetes <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Asthma <input type="checkbox"/> Depression <input type="checkbox"/> Pneumonia <input type="checkbox"/> Cancer
Are there any other relevant diagnoses or surgeries or hospitalizations?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe what for/when:	
Has the child ever been examined by a neurologist?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe findings:	
Does the client have any known food or latex allergies?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe:	
Is the client currently on any medication (OTC/prescribed)?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list:	
Does the client currently have a hearing assistive device?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe:	
Vision History	Do you have concerns about the client's vision? <input type="checkbox"/> No <input type="checkbox"/> Yes Does the client wear glasses? <input type="checkbox"/> No <input type="checkbox"/> Yes Is there a family history of vision problems? <input type="checkbox"/> No <input type="checkbox"/> Yes   If yes, explain _____ When was the client's vision last assessed? _____	

**Presenting Complaints:**

In your own words, describe what concerns you have that led to the speech therapy visit::

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What do you hope to gain, or questions do you hope to have answered, from this evaluation experience?

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<p>What has been done to address the concern up to the date of this referral? (If the client has had previous speech-language or hearing evaluations or therapy, please indicate where and approximate dates)</p>	<p><input type="checkbox"/> Speech-Language Therapy _____</p> <p><input type="checkbox"/> Occupational Therapy _____</p> <p><input type="checkbox"/> Physical Therapy _____</p> <p><input type="checkbox"/> Behavior Counseling _____</p> <p><input type="checkbox"/> Genetic Counseling _____</p> <p><input type="checkbox"/> ABA _____</p> <p><input type="checkbox"/> Other _____</p>
<p>Is the client aware of the problem?</p>	<p><input type="checkbox"/> No    <input type="checkbox"/> Yes    If yes, how do you know?:</p>
<p>Does anyone in the family have similar struggles?</p>	<p><input type="checkbox"/> No    <input type="checkbox"/> Yes    If yes, please explain:</p>

**Description of the Problem:**

<p>Please describe your voice problem: (Check all that apply.)</p>	<p><input type="checkbox"/> Hoarseness (coarse or scratchy sound)</p> <p><input type="checkbox"/> Fatigue (voice tires)</p> <p><input type="checkbox"/> Too soft</p> <p><input type="checkbox"/> Too loud</p> <p><input type="checkbox"/> Breathiness</p> <p><input type="checkbox"/> Rough</p> <p><input type="checkbox"/> Raspy</p> <p><input type="checkbox"/> Strained</p> <p><input type="checkbox"/> Nasal</p> <p><input type="checkbox"/> Loss of voice</p> <p><input type="checkbox"/> Voice breaks</p> <p><input type="checkbox"/> Pitch too high</p> <p><input type="checkbox"/> Pitch too low</p>
<p>When did the client first notice the problem?</p>	<p>_____</p> <p>_____</p> <p>_____</p>
<p>How did the problem begin?</p>	<p><input type="checkbox"/> Suddenly</p> <p><input type="checkbox"/> Gradually</p> <p><input type="checkbox"/> Intermittently</p>
<p>How has the voice problem changed since the onset?</p>	<p><input type="checkbox"/> Improved</p> <p><input type="checkbox"/> Worsened</p> <p><input type="checkbox"/> No change</p> <p><input type="checkbox"/> Fluctuates</p>
<p>Describe if or how the client's voice changes: (Please check all that apply.)</p>	<p><input type="checkbox"/> When you talk a lot</p> <p><input type="checkbox"/> When the weather changes</p> <p><input type="checkbox"/> With the time of day</p> <p><input type="checkbox"/> When you feel excited, angry, or anxious</p> <p><input type="checkbox"/> Other _____</p>

**Voice Symptoms:**

<p>Has the client had any of the following symptoms? (Check all that apply)</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Hoarseness lasting more than one week</li> <li><input type="checkbox"/> Tired voice after lengthy talk</li> <li><input type="checkbox"/> Tension in neck muscles</li> <li><input type="checkbox"/> Pain in neck muscles</li> <li><input type="checkbox"/> Need to clear throat</li> <li><input type="checkbox"/> Excessive coughing</li> <li><input type="checkbox"/> Dry throat and/or mouth</li> <li><input type="checkbox"/> Shortness of breath while speaking or singing</li> <li><input type="checkbox"/> Loss of voice</li> <li><input type="checkbox"/> Change in pitch</li> <li><input type="checkbox"/> Difficulty maintaining a loud voice</li> <li><input type="checkbox"/> Sore throat</li> <li><input type="checkbox"/> Fullness in nose and throat</li> <li><input type="checkbox"/> Tightness in nose and throat</li> <li><input type="checkbox"/> Feeling of lump in the throat</li> <li><input type="checkbox"/> Scratchy throat</li> </ul>
<p>Has the client seen a physician for their voice?</p>	<p><input type="checkbox"/> No   <input type="checkbox"/> Yes If yes, for what reasons?:</p> <p>Physician name: _____</p> <p>Address: _____</p>
<p>Has the client ever seen a speech-language pathologist?</p>	<p><input type="checkbox"/> No   <input type="checkbox"/> Yes If yes, for what reasons?:</p> <p>Speech Pathologist name: _____</p> <p>Address: _____</p>
<p>If the client received advice or treatment for a voice problem, what recommendations were given?</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Voice rest</li> <li><input type="checkbox"/> Humidification</li> <li><input type="checkbox"/> Surgery</li> <li><input type="checkbox"/> Voice therapy</li> <li><input type="checkbox"/> Medications</li> <li><input type="checkbox"/> Anti-reflux program</li> <li><input type="checkbox"/> Voice instruction</li> <li><input type="checkbox"/> Vocal hygiene instructions (e.g. reduce throat clearing, reduce loud talking)</li> <li><input type="checkbox"/> Other _____</li> </ul>

When is the client's voice best?	<input type="checkbox"/> Early morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night
When is the client's voice the worst?	<input type="checkbox"/> Early morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night
What do you think caused the client's voice problem?	<hr/> <hr/> <hr/>
What is the client's goal for speech therapy?	<hr/> <hr/> <hr/>

**Personal/Lifestyle:**

Does the client currently smoke?	x No x Yes
Did the client ever smoke?	x No x Yes
If you answered "yes" to either:	How many packs a day? _____ How many years of smoking? _____ If you used to smoke, when did you stop? _____
Indicate the client's consumption of the following beverages:	Alcohol x No x Yes If yes, how much per week? _____ Caffeinated coffee or tea x No x Yes If yes, how much per day? _____ Caffeinated soda x No x Yes If yes, how much per day? _____ Water x No x Yes If yes, how much per day? _____
What is the client's current job? (If applicable)	<hr/>
Is the client exposed to fumes/dust/particles at home or on the job?	x No x Yes
In what types of physical activities (e.g., exercise) does the client participate regularly?	<hr/> <hr/>
At what time does the client usually eat their last meal or snack?	<hr/>
Does the client play any musical instruments?	x No x Yes If yes, what instrument? _____

**Voice Use:**

Does the client's occupation require them to	x No x Yes
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use their voice frequently?	
How much does the client use their voice daily? Please check all that apply:	<input type="checkbox"/> Typical daily conversation <input type="checkbox"/> High phone use or conference calls <input type="checkbox"/> Leading meetings/trainings <input type="checkbox"/> Calling out to people or pets <input type="checkbox"/> Cheering at concerts/sports <input type="checkbox"/> Prolonged voice use (4+ hrs/day) <input type="checkbox"/> Public speaking <input type="checkbox"/> Singing or acting <input type="checkbox"/> Speaking over noise <input type="checkbox"/> Teaching/lecturing <input type="checkbox"/> Talkative
Does the client currently take voice or acting instruction?	× No   × Yes
If the client sings, what is their typical singing schedule/vocal demands?	_____ _____
If the client sings, what is their range?	Bass_____ Alto_____ Baritone_____ Soprano_____ Tenor_____
Does the client warm up before performing?	× No   × Yes
Does the client cool down after performing?	× No   × Yes
If the client sings, how long are their practice sessions/rehearsals?  How many times per week?	_____ _____

**Additional Comments:**

Please use the space below to share any additional comments or information that you feel like the diagnostic team could benefit from knowing.