Princeton Speech-Language & Learning Center

ADULT VOICE CASE HISTORY FORM

Name:_____ Date of Birth:_____
Address:_____ Age:_____
_____ Referring physician:_____
Phone:_____ Pertinent Medical Diagnosis: _____
Primary Language_____
Other Language spoken:_____
Family physician:_____ Phone:_____
Reason for referral:_____
_____

Please describe, in your own words, your voice:_____
_____
_____

What motivated you to seek advice or help regarding your voice?_____
_____
_____

II. HISTORY OF THE PROBLEM

Describe the existing voice problem._____
_____
_____
_____
When did you first notice its presence?_____
_____
What were the circumstances?_____
_____
How long has it been present?_____
_____
Do you know why it is present?_____If so, explain.____
_____
Cause_____
_____

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__
What other individuals recognize your problem?_____
_____

How would you describe your voice? (check items that apply)
Voice pitch too high____ Voice pitch too low____ Voice too loud____
Voice too soft____ Frequent pitch break ____ Infrequent pitch break ____
Harsh____ Hoarse____ Nasal____ Breathy____
Monotonous____ Difficulty controlling voice____
Voice pitch quivers____ Vocal intensity quavers_____
Other_____

Do you think the your breathing has anything to do with your voice problem?
Yes__ No__

Have you ever been a mouth breather?_____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:

| | YES | NO |
|---|---|---|
| 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?_____
Therapy? If yes, where/when?_____
_____

Did prior evaluation or therapy relate to the present problem:_____
_____

What was the nature of the evaluation and therapy?_____
_____

How effective has prior therapy been in helping his/her with the problem?_____
_____
_____

III. 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 in 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 the capacity in which you use your voice during the work day:_____
_____

Are you under stress? Yes__ No__

Is there a family history of emotional difficulties?_____

Ate there pets in the home?_____
Does anyone in the immediate family or among close associated have a similar voice problem? Yes__ No__ If so, who?_____

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IV. HEALTH HISTORY

Describe your present health_____
Is there a history of:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Allergies | ___ | ___ | Numbness | ___ | ___ |
| Sinus Infection | ___ | ___ | Paralysis/ Paresis | ___ | ___ |
| Asthma | ___ | ___ | Incoordination Of face or tongue Muscles | ___ | ___ |
| Broken Nose | ___ | ___ | Influenza | ___ | ___ |
| Bronchitis | ___ | ___ | Mouth- | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | Breathing | ___ | ___ |
| Chronic Colds | ___ | ___ | Pneumonia | ___ | ___ |
| Chronic Laryngitis | ___ | ___ | Physical defect | ___ | ___ |
| Chronic Rhinitis | ___ | ___ | Clef Palate | ___ | ___ |
| Poliomyelitis | ___ | ___ | Ear Disease | ___ | ___ |
| Rheumatic Fever | ___ | ___ | Scarlet Fever | ___ | ___ |
| Retarded sexual Development | ___ | ___ | Hearing Problem | ___ | ___ |
| Syphilis | ___ | ___ | Typhoid Fever | ___ | ___ |
| Psychological Counseling | ___ | ___ | Tremor/Twitching | ___ | ___ |
| Glandular imbalance | ___ | ___ | Ulcers | ___ | ___ |
| Hyperthyroidism | ___ | ___ | Visual Problem | ___ | ___ |
| Hypothyroidism | ___ | ___ | Hormone therapy | ___ | ___ |
| Whooping Cough | ___ | ___ | Heart Trouble | ___ | ___ |
| Hypertension | ___ | ___ | Other_____ | | |
| Drug use (non-medicinal) | ___ | ___ | | | |

If the answer to any of the above items is "Yes" give relevant details:_____

_____

_____

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 nonprescription medication used over the past year (name the type if you can not remember the brand name, i.e. aspirin, allergy pills)._____

_____

_____

Have you ever had a trauma to the head or neck? Yes_____ No_____

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?_____
_____
_____
_____

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

Additional comments or questions?_____
_____
_____
_____
_____
_____

# Cancellation Policy

Princeton Speech-Language and Learning Center is dedicated to providing quality services to our clients. We must stress that consistency of attendance is crucial in order for clients to effectively meet the goals of their treatment plan. In addition, therapy time is specifically reserved for your family and is unavailable for other clients.

We are sensitive to the needs faced by the families of our clients however; it is necessary for us to enforce a cancellation policy. Except in cases of emergency or sudden illness, appointments not cancelled **48 hours** in advance will result in a charge as though the appointment was held.

We look forward to a positive relationship with you, as we strive to provide cutting edge, quality treatment and specialized programs. Thank you for your attention to this matter.

**Signed:** _____

**Date:** _____

**FINANCIAL RESPONSIBILITY**

I hereby agree to accept full responsibility for all fees for services rendered to the patient by the practitioner. I am also aware of the cancellation policy enclosed.

Signed: _____ Date: _____

Driver's License Number: N J

# CLINICAL RELEASE OF INFORMATION

Mr.
Mrs.
I, Ms. _____, hereby give Princeton Speech-Language & Learning Center permission to discuss my case with the interdisciplinary professionals involved in my care, and to release any relevant clinical information to those professionals if requested. I also authorize PSLLC to release and/or share any information requested by my insurance company.

_____
(Client's Name)

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Signature of Patient: _____ Date: _____

Document must be signed by parent or guardian if patient is under 18 years of age.