Princeton Speech-Language & Learning Center

PEDIATRIC VOICE CASE HISTORY FORM

Name:_____ Date of Birth:_____
Address:_____ Age:_____
_____ Referred by:_____
_____ Contact person and relationship:_____
Phone: (h)_____ (w)_____
Primary Language_____
Family physician:_____ Phone:_____
Grade:_____ School:_____
Reason for referral:_____
_____

Please describe, in your own words, your child's voice:_____
_____
_____

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

I. FAMILY HISTORY:

Mother's Name:_____ Occupation: _____
Father's Name:_____ Occupation: _____
Child's caretaker/babysitter's name: _____ With child full-time or part-time?
Brothers and Sisters

Name	Age	Sex	Grade in School	Speech, Hearing or Medical Problems
1.				
2.				
3.				
4.				

Language(s) spoken in the home:_____

II. HISTORY OF THE PROBLEM

Describe the existing voice problem. _____

_____

_____

_____

When did you first notice it's presence?_____

_____

What were the circumstances?_____

_____

Did it begin suddenly or gradually? _____

How long has it been present?_____

Do you know why it is present?_____If so, explain.____

_____

Has your child been seen by an, ear, nose, and throat physician? Yes/No Date Seen:____

Name of ENT physician: _____

Results/diagnosis_____

Recommendations: _____

What other individuals recognize his/her problem?_____

_____

How would you describe his/her 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_____(e.g.,always sounds like he/she has a cold)
Monotonous _____	Difficulty controlling voice __	Breathy____
Voice pitch quivers ____	Vocal intensity quavers ____	

Other_____

Do you think his/her breathing has anything to do with his/her voice problem (e.g., asthma, shortness of breath, takes too few pauses/breaths when speaking)? Yes__ No__

Has he/she ever been a mouth breather?_____If so, when?_____

_____

Is your child aware of their voice problem? _____

How has this voice problem affected him/her?_____

_____

VARIATION OF THE PROBLEM

List 3 situations in which the voice problem is least troublesome (e.g., fatigued, end of day, first thing in the morning.)

1._____
2. _____
3. _____

List 3 situations in which the voice problem is most troublesome.

1._____
2._____
3._____

What happens to his/her voice when he/she gets:
Excited? _____
Anxious? _____
Angry? _____
Depressed? _____
Other? _____

Does he/she complain of any pain in the neck, face or ears? Yes___ No___
Describe the nature of pain _____
_____

Does he/she complain of throat pain at any of these times?

	YES	NO
Morning?	☐	☐
Evening?	☐	☐
After talking for extended periods of time?	☐	☐

When is his/her voice better? (check items that apply)

- ☐ In the morning
- ☐ Midday
- ☐ Evening
- ☐ No change during the day

How often does he/she "lose" his/her voice? _____

Has he/she ever received any prior speech, voice or hearing evaluations? _____

Therapy? If yes, where, when, and why _____
_____

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

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

Have you tried to do anything to help correct his/her voice problem?_____
Explain._____
Was it successful?_____

III. FAMILY AND ENVIRONMENTAL INFORMATION

Are there other members of the family with voice or speech problems? Yes__ No___
If yes, describe the nature of the problem and relation of person to your child in each case._____
_____
_____

Description of voice 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			
Caffeine consumption			
Whispering			

Any singing experience? Yes__ No__
If yes, please describe_____
_____
Is he/she exposed to second-hand smoke? _____

Is he/she under stress? Yes__ No__

Is there a family history of emotional difficulties?_____

Are 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? _____
_____
_____

Please describe your child's personality _____
_____

Please describe your child's behavior with parents and with siblings _____

IV. HEALTH HISTORY

Describe your child's 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 an of the above items is "Yes" give relevant details: _____
_____
_____

List periods of hospitalization or medical treatment:

	Hospital	Date	Reason
1.			
2.			
3.			

List all surgical procedures (related or unrelated to the voice problem)._____

_____

_____

Has your child ever been intubated? _____

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)._____

_____

_____

Has he/she ever had a trauma to the head or neck? Yes_____ No_____

Has he/she ever had a neurological examination? Yes_____ No_____ If so, by Whom, when, where, and why? _____

_____

_____

V. DEVELOPMENTAL HISTORY

Were there any difficulties with speech, language development? If yes, please explain_____

_____

How do you feel this clinic can assist your child?_____

_____

_____

_____

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

_____

_____

_____

_____

_____

Additional comments or questions?_____

_____

_____

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: NJ _____

CANCELLATION POLICY

Princeton Speech and Language 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: _____

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient's Name _____

Patient's Address _____

_____

Patient's Telephone Number _____

I hereby authorize Princeton Speech and Language Center to release and/or share any information regarding _____, including the diagnosis and records of any treatment or evaluation to third parties, which include relevant insurance companies, educational, and medical professionals involved in the care of _____. By signing this authorization, I am releasing and holding harmless Princeton Speech and Language Center from all legal liabilities in connection with the provision of the aforementioned patient information.

_____ _____

Signature of Parent/Legal Guardian Date

_____

Relationship to Patient