**EASTERN KENTUCKY UNIVERSITY**

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College of Education
Department of Special Education
Speech/Language/Hearing Clinic

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# ADULT VOICE CASE HISTORY FORM
# IDENTIFYING INFORMATION

Name:_____ _____
(Last) (First) (Middle) (Date)

Address:_____
(City) (State) (Zip Code)

D.O.B._____ Age:_____ Gender:_____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Occupation:_____ Education: (Check one) High School___ College___

Marital Status: (check one) Single____ Married____ Widowed____ Divorced____

Spouse's Name:_____

Children (names and ages):_____

_____

Referred By: _____

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## VOICE HISTORY

What is the problem that brings you here today?_____

_____

When did you first start to notice this problem? _____

_____

Have you ever experienced any previous voice changes or difficulties? If yes, explain: _____

_____

How would you describe the severity of your voice problem? _____

_____

Has the problem changed since you first noticed it? If yes, explain: _____

_____

Prior to today, did you consult a health professional about this problem? If yes, who? _____

_____

Have you ever been treated by an ear, nose, and throat doctor (ENT) in the past? If yes, explain. _____

_____

_____

Have you ever been seen by a speech-language pathologist in the past? If yes, explain. _____

_____

_____

Has anyone in your family ever had a voice problem? If yes, explain. _____

_____

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**VOICE SYMPTOMS**

How would you describe your voice symptoms (e.g., hoarse, breathy, tight, strained, weak, monotonous)? _____

_____

Does your voice change during the day? If yes, explain. _____

_____

On a 5 point scale where 1 = very mild and 5 = very severe, how would you rate your vocal symptoms?

| | | | | | |
|---|---|---|---|---|---|
| Shout or scream | 1 | 2 | 3 | 4 | 5 |
| Talk loudly | 1 | 2 | 3 | 4 | 5 |
| Talk a lot | 1 | 2 | 3 | 4 | 5 |
| Talk over noise | 1 | 2 | 3 | 4 | 5 |
| Use the phone | 1 | 2 | 3 | 4 | 5 |
| Sing | 1 | 2 | 3 | 4 | 5 |

On a scale of 0-5, where 0 = never and 5 = always, how often do you do the following?

| | | | | | | |
|---|---|---|---|---|---|---|
| Shout or scream | 0 | 1 | 2 | 3 | 4 | 5 |
| Talk loudly | 0 | 1 | 2 | 3 | 4 | 5 |
| Talk a lot | 0 | 1 | 2 | 3 | 4 | 5 |
| Talk over noise | 0 | 1 | 2 | 3 | 4 | 5 |
| Use the phone | 0 | 1 | 2 | 3 | 4 | 5 |
| Sing | 0 | 1 | 2 | 3 | 4 | 5 |

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**PHYSICAL SYMPTOMS**

Do you have any burning, soreness, tickling, or irritation in your throat? _____

_____

Do you sometimes have the sensation of a “lump” in the throat? _____

_____

Do you have any aching or tightness in your throat? _____

_____

Do you ever feel tension in your neck area? _____

_____

Does your voice get tired easily? _____

_____

Do you feel as if you have to strain to produce voice? _____

_____

Do you feel as if you need to cough or clear your throat a lot? _____

_____

Do you ever lose your voice completely? If yes, explain. _____

_____

Do you ever have difficulty swallowing? If yes, explain. _____

_____

Do you often get sore throats? _____

_____

Do you have difficulty projecting your voice? _____

_____

**MEDICAL HISTORY**

Have you had any major surgeries or illnesses? If yes, describe. _____

_____

Have you ever been intubated (breathing tube)? If yes, describe. _____

_____

Do you have any neurological conditions? If yes, describe. _____

_____

Do you have any respiratory problems (e.g., asthma, allergies, postnasal drip)? If yes, describe. _____

_____

Do you have acid reflux or heartburn? If yes, describe. _____

_____

Do you have any hormonal problems (e.g., hypo- or hyperthyroidism)? If yes, describe. _____

_____

If you are a female, do you take oral contraceptives or other hormonal medications? If yes, describe. _____

_____

List all medications you take, including prescription, over-the-counter, vitamins, and supplements. _____

_____

_____

Circle if you have ever had any of the following:

| | | |
|---|---|---|
| AIDS | Arthritis | Cancer |
| Chronic fatigue | Depression | Diabetes |
| Dizziness | Ear infections | Ear pain/tinnitus |
| Eating disorder | Headaches | Hearing loss |
| Heart disease | Hiatal hernia | Nasal blockage |
| Neck injury | Psychiatric disorder | Seizures |
| Sinus problems | Sleep problems | Stroke |
| Temporomandibular joint problems | Weight loss | Tremor |
| Ulcer | | |

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**OCCUPATIONAL VOICE DEMANDS**

Are you a professional voice user (e.g., teacher, salesperson, customer service representative, etc.)? If yes, explain. ____

_____

Are you a professional or amateur singer? If yes, explain. _____

_____

On a scale of 1-5 where 1 = very little and 5 = excessive, how would you characterize your daily average voice use?

1 2 3 4 5

Is there a high level of noise in your workplace? If yes, explain. _____

_____

Are you exposed to fumes, pollutants, and other irritants in your workplace (e.g., ammonia, chemicals, dust, etc.)? If yes, explain. _____

_____

**LIFESTYLE CONSIDERATIONS**

How many people live in your house? _____

How many children live with you? _____

Do you have an active social life? Explain. _____

_____

Does anyone in your family or your social circle have a hearing loss? _____

_____

What are your hobbies? _____

_____

Do you participate in activities such as debate, cheerleading, singing, etc.? If yes, explain. _____

_____

Do you smoke? If yes, how many cigarettes/cigars per day? _____

_____

If no, did you smoke previously? When? _____

_____

Do you drink alcohol? If yes, how much per week? _____

_____

Do you drink caffeinated beverages (e.g. tea, coffee, soda)? If yes, how many per day? _____

_____

Do you exercise on a regular basis? If yes, how often per week? _____

_____

Do you have a healthy diet? Explain. _____

_____

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