PROFESSIONAL VOICE CARE CENTER

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CASE HISTORY FORM

PLEASE PRINT ALL INFORMATION Today's Date: _____

Name:	**Date of Birth:**	**Age:**	**Sex:**
Home Address: (please include city, state & zip)			
Home Phone:	**Business Phone:**	**Cell Phone:**	
Occupation or School:		**Grade:**	
Marital Status:	**Spouses Name:**	**Number of Children:**	
Referred By: (If referred by a physician or another speech pathologist, please give address and phone number)			

SPEECH, VOICE OR HEARING HISTORY

Describe your speech, voice or hearing problem:

When was this problem first noticed? What were the circumstances? Was there a triggering event or illness?

Has the problem become better or worse? Describe any changes.

Describe how you use your speaking voice, and, if applicable, your singing voice, and in what quantity, both professionally and personally:

Describe the severity of the problem. Does the severity vary? (e.g. morning vs. evening, with continued vocal use, etc.)

What do you think caused the problem?

What has been done about the problem? What sort of treatment has been attempted?

Have you ever had speech therapy, voice therapy?

DATE:
THERAPIST:
ADDRESS:
LENGTH OF THERAPY:

What were the results of the therapy?

Do other members of the family have a speech, voice or hearing problem?

Describe any pertinent or related medical or psychological factors (conditions, special evaluations, diseases, hospitalizations, counseling, treatment). Include hearing problems, stress-related difficulties, etc.) PLEASE USE THE BACK OF THIS PAGE IF YOU NEED MORE SPACE.

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VOICE ABUSE QUESTIONNAIRE

Please rate how frequently you do each of the following behaviors, using the rating scale below:

RATING SCALE
0 = Never, 1 = Sometimes, 2 = Often, 3 = Very Frequently

BEHAVIOR	RATING	COMMENTS
A. Yelling or screaming		
B. Speaking loudly		
C. Shouting across a distance		
D. Speaking/singing over loud background noise, music, TV, etc.		
E. Clearing throat		
F. Coughing		
G. Vocal imitations/sound effects		
H. Heavy lifting		
I. Being in a dry/dusty/fumy environment		
J. Not drinking enough water		
K. Going into smoke-filled areas		
L. Using a belting/screaming singing style		
M. Use of over-drying medications, such as antihistamines		
N. Whispering		
O. Shouting at sporting events		
P. Excessive laughing and/or crying		
Q. Consuming caffeinated coffee, tea, soda		
R. Consuming alcoholic beverages		

How much of each of the following do you have daily:

Water: _____ oz

Caffeine (coffee, tea, iced tea, cola): _____ oz

Alcohol: _____ drinks/day

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Name: _____

Date: _____

Rate the ***overall*** severity of your voice problem: Mild Mild-Moderate Moderate Moderate-Severe Severe

Circle the response that indicates how frequently you have the same experience.

0 = Never 1 = Almost Never 2 = Sometimes 3 = Almost Always 4 = Always

VHI-10 Instructions: These are statements that many people have used to describe their voices and the effects of their voices on their lives.

My voice makes it difficult for people to hear me.	0	1	2	3	4
People have difficulty understanding me in a noisy room.	0	1	2	3	4
My voice difficulties restrict personal and social life.	0	1	2	3	4
I feel left out of conversations because of my voice.	0	1	2	3	4
My voice problem causes me to lose income.	0	1	2	3	4
I feel as though I have to strain to produce voice.	0	1	2	3	4
The clarity of my voice is unpredictable.	0	1	2	3	4
My voice problem upsets me.	0	1	2	3	4
My voice makes me feel handicapped.	0	1	2	3	4
People ask, "What's wrong with your voice?"	0	1	2	3	4

(>11) Total: _____

RSI Instructions: These are statements that many people have used to describe different "throat" symptoms and the effects on their lives. Within the last MONTH, how did the following problems affect you?

Hoarseness or a problem with your voice	0	1	2	3	4
Clearing your throat	0	1	2	3	4
Excess throat mucus	0	1	2	3	4
Difficulty swallowing food, liquids or pills	0	1	2	3	4
Coughing after eating or after lying down	0	1	2	3	4
Breathing difficulties or choking episodes	0	1	2	3	4
Troublesome or annoying cough	0	1	2	3	4
Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4
Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4

(>13) Total: _____

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LIST OF ALL MEDICATIONS/HERBALS/SUPPLEMENTS

NAME OF PATIENT: _____ DATE: _____

I take the following prescription medications:

Name of Medication	Dosage	Frequency	How Administered

I take the following over-the-counter medications:

I take the following herbals, vitamins/minerals, and dietary/nutritional supplements:

Additional comments regarding my medications:

_____
_____
_____
_____
_____