MAIA C. KING
SPEECH -LANGUAGE PATHOLOGIST, PLLC
917.579.9872

Name:_____ Date of Birth:_____
Address:_____ Age:_____
_____ Primary Care Physician :_____
Phone:_____
Specialists (ENT, NEURO, GASTRO ETC) _____
_____
Phone: _____
Pertinent Medical Diagnosis: _____
Primary Language_____
Other Language spoken:_____
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:_____
_____

Do you have a history of a swallowing disorder or difficulty swallowing ?
_____

Do you cough or clear your throat consistently after eating or drinking?
_____

Do you feel as if something is stuck in your throat at times after eating or drinking?_____
Do you have a history of head and neck cancer or a thyroid condition?
_____

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__

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?_____

IV. HEALTH HISTORY

Describe your present health_____
Is there a history of:

	Yes	No		Yes	No
Allergies	___	___	Numbness	___	___

Sinus Infection ___ ___ Paralysis/
Paresis ___ ___

Asthma ___ ___ In coordination
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 ___ ___
Hearing Problem ___ ___
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 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?_____