# VOICE INTAKE SHEET

**Please complete this form as thoroughly as possible. You may feel free to discuss any questions with your therapist at the time of the evaluation.**

|  |  |
| --- | --- |
| **Date of Evaluation:** |  |
| **Name:** |  |
| **Address:** |  |
| **Phone:** |  |
| **Date of Birth:** |  |
| **Primary MD:** |  |
| **Referring MD:** |  |
| **Occupation:** |  |

|  |  |
| --- | --- |
| **Describe the problem in your own words:** |  |
| **Date of Onset of Problem:** |  |
| **What do you think caused this problem?** |  |
| **Was Onset of Problem:** | **🞎 GRADUAL 🞎 SUDDEN** |
| **What specific times is it better/worse:** | **🞎 MORNING 🞎 AFTERNOON**  **🞎 EVENING 🞎 ALL OF THE TIME**  **🞎 NO SPECIFIC TIMES** |
| **Have you been evaluated by an ENT (Ear, Nose, and Throat Doctor)** | **🞎 YES**  **🞎 NO** |
| **Date of Consult with ENT:** |  |
| **Findings from Consult:**  **(if you have written report please provide)** |  |
| **Previous Voice Therapy with Speech-Language Pathologist** | **🞎 YES If Yes when, where and how long:**  **🞎 NO** |

##### Current Laryngeal Issues/History

|  |  |  |  |
| --- | --- | --- | --- |
| **Does it feel effortful to speak:** | **No** | **Yes** |  |
| **Do you have pain in throat or eat:** | **No** | **Yes** | **If yes, when and long does it last:** |
| **Pain Scale 1-10:** |  |  |  |
| **Have you ever lost your voice:** | **No** | **Yes** | **If yes, how often and for how long:** |
| **Do you frequently cough or clear throat:** | **No** | **Yes** |  |
| **Do you have any swallowing difficulties:** | **No** | **Yes** | **If yes, describe:** |

Self-Rating

|  |  |
| --- | --- |
| **Rate your voice on a scale of 1-5 (1-normal)-(5-severe):** |  |
| **Rate the effect your voice disorder has on your daily life 1-5:**  **(1-no effect) (5-totally disabling)** |  |
| **In your own words, how does your voice disorder affect your life?** |  |
| **How do significant others feel about your voice?** |  |

**If you have any of the following, please indicate below:**

|  |  |
| --- | --- |
| **🞎 High Blood Pressure** | **🞎 Osteoarthritis** |
| **🞎 Heart Disease** | **🞎 Fibromyalgia Symdome (FMS)** |
| **🞎 Heart Attack: Date:** | **🞎 Depression** |
| **🞎 Pacemaker** | **🞎 Kidney Disease** |
| **🞎 Stroke/TIA: Date:** | **🞎 Alcoholism/Illicit Drug Use** |
| **🞎 Concussion/Head Injury Date:** | **🞎 HIV Disease/AIDS** |
| **🞎 Respiratory Problems** | **🞎 Developmental Disabilities** |
| **🞎 Asthma** | **🞎 Latex Allergy** |
| **🞎 Emphysema** | **🞎 Bulimia** |
| **🞎 Cancer: What type?:** | **🞎 Diabetes Type:** |
| **🞎 Parkinson’s Disease** | **🞎 Seizures** |
| **🞎 Alzheimer’s Disease** | **🞎 Multiple Sclerosis** |
| **🞎 Thyroid Disease** | **🞎 Hepatitis** |
| **🞎 Reflux/GERD/LPR** | **🞎 Anemia** |
| **🞎 Allergies: Please List:** | **🞎 Other:** |
| **Additional Medical Problems/Surgeries History:** |  |

**Please list all medications you are currently taking and dosage (include over the counter):**

|  |  |
| --- | --- |
| **1.** | **11.** |
| **2.** | **12.** |
| **3.** | **13.** |
| **4.** | **14.** |
| **5.** | **15.** |
| **6.** | **16.** |
| **7.** | **17.** |
| **8.** | **18.** |
| **9.** | **19.** |
| **10.** | **20.** |

**Do You:**

|  |  |  |
| --- | --- | --- |
| **Smoke** | **🞎 YES 🞎 NO** | **# of cigarettes a day:** |
| **Drink Caffeinated Beverages** | **🞎 YES 🞎 NO** | **# of caffeinated beverages per day:** |
| **Drink Alcoholic Beverages** | **🞎 YES 🞎 NO** | **# of alcoholic beverages per week:** |

**Is there a family history of voice and speech problems: Yes No**

**Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If yes please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please provide us with your goal for voice therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**AVAILABILITY:**

**Please indicate the days/times you are available to come for voice therapy:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| **9-11:30am** |  |  |  |  |  |
| **1-3:30pm** |  |  |  |  |  |
| **3:30-5pm** |  |  |  |  |  |
| **After 5pm** |  |  |  |  |  |

**Pain Assessment**

Are you currently in pain? 🞎 Yes 🞎 No

On a scale from 0 to 10, please rate your pain (10 is most severe pain):\_\_\_\_\_\_\_\_\_\_\_\_

If yes, where is your pain located?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will your pain interfere with completing this assessment today? 🞎 Yes 🞎 No

*🞎 Recommend follow-up with physician*

**Advanced Directives**

Do you have an advanced directive? 🞎 Yes 🞎 No

If no, are you interested in information about an Advanced Directive? 🞎 Yes 🞎 No

*🞎 Information given*

**Social Assessment**

Do you feel safe in your home environment? 🞎 Yes 🞎 No

Are you being hurt or threatened by anyone? 🞎 Yes 🞎 No

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*🞎 Referral to Social Services*

Reviewed assessment with patient and/or family; appropriate referrals made as above.

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

Clinician’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_