

**History of Problem (Voice)**

**Please note that a current (within six months) evaluation from an Ear, Nose and Throat physician is required before a voice treatment program can be designed and implemented. For this reason, a written report is required as part of the speech evaluation.**

**All questions on both pages must be answered.**

Characteristics of the voice problem (check all that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> too high in pitch     | <input type="checkbox"/> too nasal                               | <input type="checkbox"/> hoarse voice                  |
| <input type="checkbox"/> too low in pitch      | <input type="checkbox"/> "stuffed up" quality (denasal)          | <input type="checkbox"/> quivering voice               |
| <input type="checkbox"/> variable in pitch     | <input type="checkbox"/> breathy voice                           | <input type="checkbox"/> tremor in the voice           |
| <input type="checkbox"/> too loud              | <input type="checkbox"/> shrill voice                            | <input type="checkbox"/> weak voice                    |
| <input type="checkbox"/> too soft or quiet     | <input type="checkbox"/> strident voice (squeaky noise in voice) | <input type="checkbox"/> progressively weakening voice |
| <input type="checkbox"/> variable in loudness  | <input type="checkbox"/> harsh voice                             | <input type="checkbox"/> loss of voice                 |
| <input type="checkbox"/> other (specify) _____ |  |  |

Describe the problem in your own words: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did the problem begin? (Suddenly or over a period of time?) \_\_\_\_\_

Do you believe your voice differs from the voice of others of the same sex and age as you? Y N  
If so, how? \_\_\_\_\_

Does the voice fluctuate or is it consistent? \_\_\_\_\_

Is there any pain, irritation, or discomfort? Y N If so, describe: \_\_\_\_\_

What do you believe causes and/or contributes the most to the problem? \_\_\_\_\_  
\_\_\_\_\_

Describe any changes related to specific situations (e.g., is worse in the evening than in the morning): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What limitations or problems have been experienced as a result of the voice problem? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In what ways do you believe your voice needs to be improved? \_\_\_\_\_

Have there been previous medical and/or speech assessments? Y N Where? \_\_\_\_\_ By whom? \_\_\_\_\_  
When? \_\_\_\_\_ Describe: \_\_\_\_\_

Have there been previous medical and/or speech treatment? Y N Where? \_\_\_\_\_ By whom? \_\_\_\_\_  
When? \_\_\_\_\_ Describe: \_\_\_\_\_

**Please attach or have copies sent of any relevant reports from other agencies.**

Describe the home environment (noisy? tense? competitive? smokey? etc.) \_\_\_\_\_

Describe the work environment (noisy machinery? dusty? smokey? etc.) \_\_\_\_\_

What do you hope to gain from the present evaluation? \_\_\_\_\_

What do you hope to gain from treatment? \_\_\_\_\_

Is there anything else you would like us to know? \_\_\_\_\_