Child Voice Case History

Please fill out this form as completely as possible and send these forms to our office TWO DAYS prior to your evaluation. If you need more space, attach another page. We look forward to meeting you.

I. GENERAL INFORMATION Date:_____

Patient Name:_____ Date of Birth:_____

Parent(s) names:_____

Primary Care Physician:_____ Phone:_____

Address:_____ Fax:_____

_____

Referring Physician (if different):_____ Phone:_____

Address:_____ Fax:_____

_____

What is your child's native language?_____

II. HISTORY OF THE PROBLEM

1. Briefly describe the reasons for seeking an evaluation?_____

   _____
2. What symptoms are your child currently experiencing?_____

   _____
3. When did these symptoms begin?_____

   _____
4. Were there any events or conditions with which you can associate the onset of the symptoms?_____

   _____
5. Are there any situations in which your child's voice is better or seems to improve?_____

_____

6. Has your child had the same or similar problems in the past?_____

_____

7. Has your child been to any specialists in relation to these symptoms? If so, whom have you seen?_____

_____

8. Has your child ever had any surgery or other medical procedures to the larynx or the respiratory system?_____
9. Is your child's voice worse at certain times of the day?

____ no variation
____ upon wakening
____ early in the day
____ middle of the day
____ end of the day
____ lack of sleep
____ during work hours
____ other (specify)_____

10. Do you have a family history of speech, language, voice, cognition or hearing problems? (Please specify)_____

_____

11. Has your child ever received voice therapy in the past?

When_____

Duration _____

Therapist Name_____

Please give a brief description of what your child did in therapy?_____

_____

12. What vocal symptoms is your child experiencing?

Please check all that apply to you:

___ no voice at all
___ whisper only
___ weak cry
___ breathy-weak tone
___ raspy voice quality
___ scratchy voice quality
___ voice seems high
___ voice seems low
___ unsteady/shaky voice
___ voice breaks
___ trouble speaking loudly
___ trouble speaking softly
___ effortful voicing/strain
___ voice fatigues easily
___ air escapes through nose
___ stuffed nose quality
___ tickling sensation in throat
___ frequent dry throat
___ frequent throat clear
___ pain in throat/ irritation
___ lump in throat sensation
___ frequent coughing
___ throat clicks sensation
___ other (specify)_____

13. Does your child participate in fewer social activities since the current difficulties began? For example, is your child less talkative?_____

_____

14. How much water does your child drink daily?_____
15. Please list any allergies your child has (medications, environmental)?_____

_____

III. SWALLOWING

1. Does your child cough or choke while eating or just after a meal? If yes, please describe the nature and frequency of the problem?_____

_____

IV. MEDICAL HISTORY

1. Please check any of the conditions your child currently has or had in the past:
   ___ Premature birth
   ___ Hoarseness first thing in the am
   ___ Night coughing that interrupts sleep
   ___ Allergies
   ___ weakness/paralysis of face
   ___ Asthma
   ___ Headaches
   ___ Hearing loss
   ___ Difficulty swallowing
   ___ Shortness of breath
   ___ Insomnia
   ___ OCD
   ___ Anxiety
   ___ Depression
   ___ Reflux
   ___ Cleft Palate
   ___ Seizures
   ___ Diabetes
   ___ Autism/Asperger's
   ___ Frequent ear infections
   ___ ADD/ADHD
   ___ Frequent sinus infections
   ___ Other (Please specify)_____

2. Please indicate any medical procedures your child has had:

_____

_____

3. Please list any medications your child takes:

_____

_____