Voice and Swallow Clinics

Medical Intake Form for **Voice (Revisit)** Patients

Date: _____

MRN (Staff Input) _____

Name: _____

Date of birth: _____

› Please indicate if your occupation has changed since your initial visit:

Occupation: _____ (Circle) full-time / part-time / unemployed / retired / disabled

› Primary concern today:

- ☐ Voice Effort
- ☐ Voice Quality
- ☐ Voice Quality and effort
- ☐ Other: _____

1. Current Voice concerns/symptoms

› Has your voice changed since your last evaluation? ☐ Yes ☐ No
If yes, please describe:

› If you answered yes, are there any events or circumstances that you associate with the improvement or deterioration in your voice since the initial evaluation?

Event	Has made my voice			
Voice therapy	☐ Better	☐ No change	☐ Worse	☐ Not applicable
Change of diet	☐ Better	☐ No change	☐ Worse	☐ Not applicable
Stopped smoking	☐ Better	☐ No change	☐ Worse	☐ Not applicable
Change in medications	☐ Better	☐ No change	☐ Worse	☐ Not applicable
Surgery	☐ Better	☐ No change	☐ Worse	☐ Not applicable
Other: _____	☐ Better	☐ No change	☐ Worse	☐ Not applicable

› Please indicate the nature of your present vocal difficulties:

☐ NONE
☐ Hoarseness
☐ Breathiness in speaking voice
☐ Fatigue (voice tires/quality changes)
☐ Voice breaks
☐ Whisper only (total loss of voice)
☐ Trouble speaking softly
☐ Trouble speaking loudly
☐ Voice is lower
☐ Voice is higher
☐ Voice is weaker
☐ Vocal strain
☐ Periods of normal voice
☐ Sore throat
☐ Lump in throat
☐ Difficulty with the telephone
☐ Trouble singing
☐ Tickling or choking sensation
☐ Difficulty swallowing
☐ Frequent throat clearing
☐ Frequent dry throat
☐ Frequent coughing
☐ Nasality

Since your initial evaluation,

› Voice use in general prior to current voice problems:
☐ Minimal ☐ Normal ☐ Moderate ☐ Heavy

› Voice use at home prior to current voice problems:
☐ Minimal ☐ Normal ☐ Moderate ☐ Heavy

› Voice use at work prior to current voice problems:
☐ Minimal ☐ Normal ☐ Moderate ☐ Heavy

› Voice use outside work prior to current voice problems:
☐ Minimal ☐ Normal ☐ Moderate ☐ Heavy

› Has your voice problem caused you to speak less? ☐ Yes ☐ No
If yes, how much less? ☐ 25% ☐ 50% ☐ 75% ☐ 100%

› Are there things you have stopped doing because of your voice problems? ☐ Yes ☐ No
If yes, list: _____

2. Medical History

› Have you had voice/speech therapy for your concerns? ☐ Never ☐ Yes, in past ☐ Yes, currently
if yes, please describe:
Number of sessions _____ (#/wk) for the period of time _____ (months)
Length of each session _____ (minutes)
Service provider _____ location (city, state) _____
Approximate date when therapy started _____ when therapy ended _____
Goals of therapy _____
Was the therapy beneficial? ☐ Yes ☐ No

› How much of the following do you consume?

Water	☐ None	☐ 1 cup/day	☐ 2-4 cups/day	☐ 5-8 cups/day	☐ More than 8 cups/day
Caffeinated beverages	☐ None	☐ 1 cup/day	☐ 2-4 cups/day	☐ 5-8 cups/day	☐ More than 8 cups/day
Carbonated beverages	☐ None	☐ 1 cup/day	☐ 2-4 cups/day	☐ 5-8 cups/day	☐ More than 8 cups/day

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› How often do you have a drink containing alcohol?

☐ Never
☐ Monthly or less
☐ 2 to 4 times a month
☐ 2 to 3 times a week
☐ 4 or more times a week
☐ Other _____

How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ NA ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 or more

› Do you smoke? ☐ Yes ☐ No

If yes, has your smoking pattern changed and how? _____

› Have you had any new medical diagnoses since your initial evaluation? ☐ Yes ☐ No

If yes, please list: _____

3. Please rate how the following problems have affected you within the past month

	"0" = No problem					"5" = Severe problem
Hoarseness or a problem with your voice	0	1	2	3	4	5
Clearing your throat	0	1	2	3	4	5
Excess throat mucus or post nasal drip	0	1	2	3	4	5
Difficulty swallowing foods, liquids, or pills	0	1	2	3	4	5
Coughing after you eat or lie down	0	1	2	3	4	5
Breathing difficulties or choking episodes	0	1	2	3	4	5
Troublesome or annoying cough	0	1	2	3	4	5
Sensations of something sticking in your throat, or a lump in your throat	0	1	2	3	4	5
Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5
	(For staff input only) **RSI score**: _____					

4. Please rate how the following problems have affected you within the past month

	"0" = No problem					"5" = Severe problem
Speaking took extra effort	0	1	2	3	4	5
Throat discomfort or pain after using your voice	0	1	2	3	4	5
Vocal fatigue (voice weakening as you talk)	0	1	2	3	4	5
Voice "cracks" or sounds different	0	1	2	3	4	5
	(staff input only) **Glottal Function Index**: _____					

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We want to understand more about how your voice problem can interfere with your day-to-day activities. Please circle the response that indicates how frequently you have had the same experience in the last month. There are no "right or wrong" answers.

	Never	Almost Never	Some of the time	Almost Always	Always
1. My voice makes it difficult for people to hear me.	0	1	2	3	4
2. I run out of air when I talk.	0	1	2	3	4
3. People have trouble understanding me in a noisy room.	0	1	2	3	4
4. The sound of my voice varies throughout the day.	0	1	2	3	4
5. My family has difficulty hearing me when I call them throughout the house.	0	1	2	3	4
6. I use the phone less often than I would like.	0	1	2	3	4
7. I'm tense when I am talking with others because of my voice.	0	1	2	3	4
8. I tend to avoid groups of people because of my voice.	0	1	2	3	4
9. People seem irritated with my voice.	0	1	2	3	4
10. People ask "What's wrong with your voice?"	0	1	2	3	4
11. I speak with friends, neighbors, or relatives less often because of my voice.	0	1	2	3	4
12. People ask me to repeat myself when speaking face to face.	0	1	2	3	4
13. My voice sounds creaky and dry.	0	1	2	3	4
14. I feel as though I have to strain to produce voice.	0	1	2	3	4
15. I find other people don't understand my voice problem.	0	1	2	3	4
16. My voice difficulty restricts my personal and social life.	0	1	2	3	4
17. The clarity of my voice is unpredictable.	0	1	2	3	4
18. I try to change my voice to sound different.	0	1	2	3	4
19. I feel left out of conversations because of my voice.	0	1	2	3	4
20. I use a great deal of effort to speak.	0	1	2	3	4
21. My voice is worse in the evening.	0	1	2	3	4
22. My voice problem causes me to lose income.	0	1	2	3	4
23. My voice problem upsets me.	0	1	2	3	4
24. I am less outgoing because of my voice problem.	0	1	2	3	4
25. My voice makes me feel handicapped.	0	1	2	3	4
26. My voice "gives out" on me in the middle of speaking.	0	1	2	3	4
27. I feel annoyed when people ask me to repeat.	0	1	2	3	4
28. I feel embarrassed when people ask me to repeat.	0	1	2	3	4
29. My voice makes me feel incompetent.	0	1	2	3	4
30. I'm ashamed of my voice problem.	0	1	2	3	4

31. **My voice is** (please circle one):	Normal	Mildly impaired	Moderately impaired	Severely impaired

(for staff input only) **VHI scores** Functional _____ Physical _____ Emotional _____ Total _____

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SF-12v2® Health Survey Standard Version

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. **In general, would you say your health is:** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. **The following two questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:			
b. Climbing several flights of stairs:			

3. **During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular activities as a result of your physical health?**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like					
b. Were limited in the kind of work or other activities:					

4. **During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like:					
b. Did work or activities less carefully than usual					

5. **During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?** ☐ Not At All ☐ A Little Bit ☐ Moderately ☐ Quite a Bit ☐ Extremely

6. **These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?					
b. Did you have a lot of energy?					
c. Have you felt downhearted and depressed?					

7. **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**

☐ All the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time