Bay Area OUTSpoken Speech
Voice Intake Form

IDENTIFYING INFORMATION:

Name: _____ Date of birth: _____
Pronoun: _____

Are you comfortable being contacted by: ☐ Phone _____

☐ Email _____

Preferred name when contacted via phone/email (if different than above): _____

**If seeking Insurance Reimbursement- Please fill in medical insurance information:*
Name on Insurance if different: _____
Insurance Provider: _____ Medical group #:_____
Medical ID #: _____

REASON FOR REFERRAL:

Describe concerns relating to speech/voice in order of importance:

	Concern	How long has this been a concern?
1.	_____	_____
2.	_____	_____
3.	_____	_____

Have you tried any treatments for this in the past (on your own or with another professional)? If yes, please describe:

<u>HISTORY OF VOICE:</u>

History of voice problems or phonotraumatic behaviors (e.g., excessive hoarseness, breathiness, losing voice, etc). Onset? Duration? Did voice problems resolve?

Associated symptoms and sensations: pain, dryness, tickle, lump, strain, fatigue, swallowing (dysphagia or odynophagia), weight loss, heartburn, slurred speech, other?

Does your speech or voice change depending on how much you use your voice? How?

Does your voice change when you are under stress or when your emotions change (e.g., happy, sad, mad)? How?

Do other people comment on your voice?

Revised 9/2020

MEDICAL HISTORY:

Have you begun Hormone Replacement Therapy (HRT)? Yes No

If yes, have the hormones changed your voice? Or other aspects of physical appearance? Additional pleasing side effects? Please describe:

What positive transitions have you noticed since beginning HRT?

Current medication (name + dose):

OTHER HEALTH HISTORY:

Please check if you have ever had:

- ☐ Allergies
- ☐ Asthma
- ☐ Chronic congested nose
- ☐ Chronic cough
- ☐ Chronic headaches
- ☐ Chronic heartburn/acid reflux
- ☐ Chronic runny nose
- ☐ Chronic sore throat
- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Ear infections
- ☐ Frequent need to clear throat
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Loss of voice
- ☐ Pain in ears
- ☐ Pain in jaw
- ☐ Tinnitus
- ☐ Lump in throat
- ☐ Sinus Problems
- ☐ Sleep apnea

Any history of other chronic or acute medical problems? Specifically (neurological, respiratory, allergy, psychological/behavioral, gastrointestinal, GERD/LPR., etc). Please describe:

Surgery(ies) related to head, neck, or voice: (ie: trach shave, vocal nodules, other.... any intubation? Please describe:

Trauma (head or neck injury/accidents), Substance or Environmental Exposure, accidents, assault, chemical ingestion, bird owner, hot tubs, smoke/noxious gasses, burns/inhalation. Please describe:

Hearing loss? Right, Left, bilateral? Onset? Hearing Aids? Noise exposure? Or N/A

OTHER FACTORS THAT MAY AFFECT VOICE

Daily intake of water (cups/daily): _____

Other non-caffeinated, non-alcoholic drinks (e.g., milk, juice): _____

	Approx. start	Approx. end	Current daily consumption
Caffeine (*coffee, tea, soft drinks, chocolate)*	☐ Past _____	_____	☐ Current_____
Alcohol	☐ Past _____	_____	☐ Current _____
Smoking			
• Tobacco	☐ Past _____	_____	☐ Current _____
• Marijuana	☐ Past _____	_____	☐ Current _____
• Crack/Cocaine	☐ Past _____	_____	☐ Current _____
• Amphetamines	☐ Past _____	_____	☐ Current _____
• Other	☐ Past _____	_____	☐ Current _____

Talking: how much (estimate in hours/day), where, to whom, at what distance, at what volume, in what kind of environment.

Social: significant family/friend relationships, living arrangements, life style?

Do you ever scream/shout/yell? (e.g., sporting event, concert)

Do you use your voice at work? Or school? current job description, responsibilities, work/ school environment.

Do you use your voice for recreation (singing, acting, etc)?

Recreational History: exercise programs, activities, hobbies.

OTHER HEALTH PROFESSIONALS:

To assist in coordination of care, it's helpful to know about other health professionals you're working with. Do we have your consent to speak with them regarding treatment? (Please circle one) **Yes/ No.**

Other care providers will not be contacted without your permission unless there's a medical emergency.

Name of primary Care provider (GP, nurse etc.): _____

Phone/ Email: _____

Other care providers (specialists, counselors, therapists, etc)

Name: _____ Phone/ Email: _____

Name: _____ Phone/ Email: _____

Name: _____ Phone/ Email: _____

PERSONAL VOICE GOALS:

1. What are three specific things you would like to change about your speech/voice? What is your goal for yourself when therapy is over, however long that will take?
    a)
    b)
    c)

2. What are three situations in which you would like to sound more feminine/masculine?
    a)
    b)
    c)

3. List 4-6 real life situations (ranging from easiest to most difficult) in which you can practice generalizing information learned in session. For example: Reading alone in room may be easy; talking on the phone may be more challenging, etc.
    Easy tasks: 1.
    2.
    Moderate tasks: 1.
    2.
    Difficult tasks: 1.
    2.

(PLEASE Do Not fill out this page: for Clinician's Assessment Data)

Acoustic Analysis of Voice recordings

1) Sustained phonation of vowels: Formants

Formants	1	2	3
/ah/			
/i/ me			
/u/ who			

2) 2 Pitch Glides: high to low
Average: _____ Hz
Min: _____ Hz
Max: _____ Hz
ST: _____

3) Rainbow Passage
Average: _____ Hz
Min: _____ Hz
Max: _____ Hz
ST: _____

4) Conversational samples for 1 minute
Average: _____ Hz
Min: _____ Hz
Max: _____ Hz
ST: _____

5) Vocal quality: CAPE-V
Overall:___ Consistent/ Intermittent, Roughness/ Breathiness/ Strain/
Pitch:____ , Loudness ____ dB

6) Oral exam
7) Laryngeal palpation:
8) Respiratory Patterns:
Clavicular/ Thoracic/ Abdominal/ Mixed
9) Tension:
Neck/ shoulders
10) Voice parameters (<1.25", 12-15 s)
S ratio: 1) 2)
Z Ratio: 1) 2)