# New Voice/Swallowing Patient Intake Form:

## Professional History:

Occupation (List all current):

_____

Do you use your voice as a part of your professional duties? □ YES □ NO
If yes, how?

_____

Do you use your voice as a performer? □ YES □ NO If yes, how? _____

***If you are a singer**, please fill out the following section, otherwise skip to "*Prior Evaluations"*:
What is your voice type? _____ What is your style? □ Classical □ Pop/Rock
□ Musical □ Theater □ Church/Gospel
Other_____
What is your level of training (years of lessons, etc.)? _____
What are your aspirations as a singer? _____
How many hours each day/week do you spend in:
Rehearsal? _____ Performance? _____

## Prior Evaluations:

Have you ever been assessed by an Ear, Nose and Throat specialist (aka an Otolaryngologist)?
□ YES □ NO

If yes, When:_____ Name of Specialist:_____
Reason for consultation:

_____

## Reflux History:

Do you suffer from reflux (e.g., take antacids, taste stomach acid in mouth, sit up in middle of the night, belch frequently)? □ YES □ NO

If yes, are you currently taking any medication to treat reflux? If yes, what is the name of the medication? □ YES _____ □ NO
Was your reflux diagnosed by a medical professional or was it self-diagnosed?
□
Medical professional □ Self Diagnosed

## Allergy History:

Do you suffer from hay fever (aka environmental allergies)? □ YES □ NO
If yes, are you receiving treatment (including nasal sprays, medications, allergy shots)?

_____

Have you had allergy testing? □ YES □ NO
Do you have asthma? □ YES □ NO
Do you have an allergist? □ YES □ NO If yes, please provide their name: _____

## Voice and Swallowing Symptoms Surveys

The surveys below are research-validated questionnaires that help us better understand the impact of your problem on your overall quality of life. There are no "right" or "wrong" answers. When answering, please consider both how severe the problem is when you get it, and how frequently it happens.

*If you have a problem with your voice, please fill out the following section:*

| | Never | Almost Never | Sometimes | Almost Always | Always |
|---|---|---|---|---|---|
| 1. My voice makes it difficult for people to hear me. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 2. My family has difficulty hearing me when I call them throughout the house. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 3. People have difficulty understanding me in a noisy room speaking. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 4. The sound of my voice varies throughout the day. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 5. I run out of air when I talk. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 6. I use the phone less often than I would like to. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 7. I'm tense when talking to 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 |
| | | | **VHI-10 TOTAL** | | |

*If you have a problem with swallowing, please fill out the following section:*

| | (0=NO PROBLEM | | | | 4=SEVERE PROBLEM) |
|---|---|---|---|---|---|
| 1. My swallowing problem has caused me to lose weight. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 2. My swallowing problem interferes with my ability to go out for meals. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 3. Swallowing liquids takes extra effort. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 4. Swallowing solids takes extra effort | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 5. Swallowing pills takes extra effort. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 6. Swallowing is painful. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 7. The pleasure of eating is affected by my swallowing. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 8. When I swallow food sticks in my throat. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 9. I cough when I eat | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 10. Swallowing is stressful. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| | | | **EAT-10 TOTAL** | | |