

SPEECH PATHWAYS, P.C.

Child Voice Questionnaire

Child's Name: _____ Date: _____

Medical History (Check all that apply.)

When did you begin noticing problems with your child's voice?

- more than 1 year ago
 within the six months
 within the past three months

Can you think of a specific circumstance or event contributing to the onset of the problem? If so, explain: _____

Is the problem increasing? decreasing? about the same?

Does your child complain of the following problems?

vocal pain vocal fatigue difficulty projecting his/her voice other

Explain: _____

Does your child have a history of any of the following medical conditions?

- allergies asthma accident or injury to the neck area
 hearing loss earaches sore throats sinus problems
 reflux (frequent burping/stomach upset) hormonal issues
 known vocal disease

Explain: _____

List your child's current medications: _____

List all surgical procedures with dates: _____

Is your child currently under a physician's care? If so, explain: _____

Social History (Check all that apply.)

When is your child's voice worst?

a.m. p.m. no change a.m. or p.m. fluctuates

Does your child engage in any of the following activities?

- sporting activities choir singing solo singing
 cheerleading weight lifting throat clearing
 breath holding harsh laughter vocal impersonations
 more than 4 hours of voice use per day other strenuous use

Explain: _____

Does your child yell at siblings? on the playground? across the house? other?

Explain _____

Does your child smoke or live with a smoker? If so, explain: _____

How many caffeinated beverages does your child drink daily? _____

How much decaffeinated liquid does your child drink daily? _____