

# SPEECH PATHWAYS, P.C.

## ADULT VOICE QUESTIONNAIRE

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

When did you begin noticing problems with your voice? \_\_\_\_\_

How did your voice problem begin? gradually / suddenly

Please explain: \_\_\_\_\_

Has your voice improved or gotten worse?

Please explain: \_\_\_\_\_

What is the matter with your voice? (Circle all that apply.)

hoarseness    cannot project    choking or tickling    breathiness    pain  
lump in the throat    fatigue    cannot control    prolonged warm up time    voice loss  
other \_\_\_\_\_

What kind of physical condition are you in? (Circle the one that applies.)

exercise regularly    exercises sometimes    exercise rarely

Do you have breathing problems, especially after exercise? Yes No

If yes, please describe: \_\_\_\_\_

Do you have cold or allergy symptoms? (Circle the one that applies.) Yes No

If yes, please describe: \_\_\_\_\_

What medications do you use? (List all medications.)

\_\_\_\_\_  
\_\_\_\_\_

Do you smoke, work around smoke or live with a smoker? Yes No

Have you been exposed to environmental irritants? Yes No

If yes, please describe: \_\_\_\_\_

Do any foods seem to affect your voice? Yes No

If yes, please describe: \_\_\_\_\_

Do you have TMJ problems? Yes No

Do you have morning hoarseness, bad breath, excessive phlegm or heartburn? Y/N

If yes, please describe: \_\_\_\_\_

Have you noted voice or bodily weakness, tremor, fatigue, or loss of muscle control? Yes/No If yes, please explain: \_\_\_\_\_

Are you having any difficulty swallowing? Yes No

If yes, please describe: \_\_\_\_\_

Do you have difficulty with abdominal muscle spasms/constipation/diarrhea? Y/N

**Do you have problems with any of the following symptoms?** (Circle all that apply.)

weight control      fatigue      temperature sensitivity      menstrual irregularity  
cyclical voice changes      recent menopause      other hormonal issues \_\_\_\_\_

**Has your voice been injured?** Yes No

If yes, please describe: \_\_\_\_\_

**Did you have surgery prior to your voice problem?** Yes No

If yes, please describe: \_\_\_\_\_

**List surgical procedures, dates and affect on the voice.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**When are you most aware of your voice problem?** (Circle all that apply.)

speaking      singing      speaking & singing      professional speaking  
AM      PM      high range use      low range use

**When is your voice the worst?** AM / PM

Describe any vocal fluctuations: \_\_\_\_\_

**Where do you use your voice?** (Circle all that apply.)

noisy rooms      cars      airplanes      sports facilities      dusty places  
cheerleading      teaching      preaching      choral conducting      singing  
acting      aerobics      weight lifting      other \_\_\_\_\_

**Do you or any blood relatives have a hearing loss?** Yes No

If you, please describe: \_\_\_\_\_

**Are you under any particular stress or therapy?** Yes No

If yes, please describe: \_\_\_\_\_

**Do you do any of these?** (Circle all that apply.)

throat clearing      coughing      loud singing      sound imitations  
excessive talking      loud talking      laughing      impersonations

**How many of the following beverages do you drink daily?**

caffeinated \_\_\_\_\_      alcoholic \_\_\_\_\_      decaffeinated (includes water) \_\_\_\_\_

**How much time do you use your voice per day?**

2 to 4 hours \_\_\_\_\_      5 to 7 hours \_\_\_\_\_      > 8 hours \_\_\_\_\_

**Comments:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_