Hackensack Meridian *Health*
Mountainside Medical Center

VOICE INTAKE SHEET

Please complete this form as thoroughly as possible. You may feel free to discuss any questions with your therapist at the time of the evaluation.

Date of Evaluation:	
Name:	
Address:	
Phone:	
Date of Birth:	
Primary MD:	
Referring MD:	
Occupation:	

Describe the problem in your own words:	
Date of Onset of Problem:	
What do you think caused this problem?	
Was Onset of Problem:	☐ **GRADUAL** ☐ **SUDDEN**
What specific times is it better/worse:	☐ **MORNING** ☐ **AFTERNOON** ☐ **EVENING** ☐ **ALL OF THE TIME** ☐ **NO SPECIFIC TIMES**
Have you been evaluated by an ENT (Ear, Nose, and Throat Doctor)	☐ **YES** ☐ **NO**
Date of Consult with ENT:	
Findings from Consult: **(if you have written report please provide)**	
Previous Voice Therapy with Speech-Language Pathologist	☐ **YES** **If Yes when, where and how long:** ☐ **NO**

Current Laryngeal Issues/History

Does it feel effortful to speak: ☐ **No** ☐ **Yes**

Do you have pain in throat or eat: ☐ **No** ☐ **Yes** **If yes, when and long does it last:**

Pain Scale 1-10:

Have you ever lost your voice: ☐ **No** ☐ **Yes** **If yes, how often and for how long:**

Do you frequently cough or clear throat: ☐ **No** ☐ **Yes**

Do you have any swallowing difficulties: ☐ **No** ☐ **Yes** **If yes, describe:**

Self-Rating

Rate your voice on a scale of 1-5 (1-normal)-(5-severe):	
Rate the effect your voice disorder has on your daily life 1-5: (1-no effect) (5-totally disabling)	
In your own words, how does your voice disorder affect your life?	
How do significant others feel about your voice?	

If you have any of the following, please indicate below:

☐ **High Blood Pressure**	☐ **Osteoarthritis**
☐ **Heart Disease**	☐ **Fibromyalgia Symdome (FMS)**
☐ **Heart Attack: Date:**	☐ **Depression**
☐ **Pacemaker**	☐ **Kidney Disease**
☐ **Stroke/TIA: Date:**	☐ **Alcoholism/Illicit Drug Use**
☐ **Concussion/Head Injury Date:**	☐ **HIV Disease/AIDS**
☐ **Respiratory Problems**	☐ **Developmental Disabilities**
☐ **Asthma**	☐ **Latex Allergy**
☐ **Emphysema**	☐ **Bulimia**
☐ **Cancer: What type?:**	☐ **Diabetes Type:**
☐ **Parkinson's Disease**	☐ **Seizures**
☐ **Alzheimer's Disease**	☐ **Multiple Sclerosis**
☐ **Thyroid Disease**	☐ **Hepatitis**
☐ **Reflux/GERD/LPR**	☐ **Anemia**
☐ **Allergies: Please List:**	☐ **Other:**
Additional Medical Problems/Surgeries History:	

Please list all medications you are currently taking and dosage (include over the counter):

1.	**11.**
2.	**12.**
3.	**13.**
4.	**14.**
5.	**15.**
6.	**16.**
7.	**17.**
8.	**18.**
9.	**19.**
10.	**20.**

Do You:

Smoke	**☐ YES ☐ NO**	**# of cigarettes a day:**
Drink Caffeinated Beverages	**☐ YES ☐ NO**	**# of caffeinated beverages per day:**
Drink Alcoholic Beverages	**☐ YES ☐ NO**	**# of alcoholic beverages per week:**

Is there a family history of voice and speech problems: ☐ Yes ☐ No
Relationship to you: _____
If yes please specify:_____

Please provide us with your goal for voice therapy: _____
_____
_____

AVAILABILITY:
Please indicate the days/times you are available to come for voice therapy:

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
9-11:30am					
1-3:30pm					
3:30-5pm					
After 5pm					

Pain Assessment
Are you currently in pain? ☐ Yes ☐ No
On a scale from 0 to 10, please rate your pain (10 is most severe pain):_____
If yes, where is your pain located?_____
Will your pain interfere with completing this assessment today? ☐ Yes ☐ No
☐ *Recommend follow-up with physician*
Advanced Directives
Do you have an advanced directive? ☐ Yes ☐ No
If no, are you interested in information about an Advanced Directive? ☐ Yes ☐ No
☐ *Information given*
Social Assessment
Do you feel safe in your home environment? ☐ Yes ☐ No
Are you being hurt or threatened by anyone? ☐ Yes ☐ No
Other: _____
_____
☐ *Referral to Social Services*

Reviewed assessment with patient and/or family; appropriate referrals made as above.
Patient's Signature:_____ Date:_____
Clinician's Signature:_____ Date:_____