

# Voice Diagnostic Packet

Name: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_ Follow up scheduled? YES  NO   
 Date of Birth: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone number: \_\_\_\_\_  
 \_\_\_\_\_ Email: \_\_\_\_\_

What is your goal regarding your problem or condition: \_\_\_\_\_

**History:**

Occupation: \_\_\_\_\_ When did your voice problem begin? \_\_\_\_\_

My voice problem started:  suddenly  gradually

Describe your voice problem in your own words \_\_\_\_\_

What bothers you most about your voice problem? \_\_\_\_\_

**Please check all the following symptoms that apply to you:**

- |   |   |  |
|---|---|--|
| Breathiness <input type="checkbox"/>                | Voice too loud <input type="checkbox"/>                     | Bitter or metallic taste after waking <input type="checkbox"/> |
| Roughness <input type="checkbox"/>                  | Voice too soft <input type="checkbox"/>                     | Sudden coughing after lying down <input type="checkbox"/>      |
| Gravelly voice quality <input type="checkbox"/>     | Whisper only (total loss of voice) <input type="checkbox"/> | Chronic throat clearing <input type="checkbox"/>               |
| Harsh voice quality <input type="checkbox"/>        | Straining to speak <input type="checkbox"/>                 | Chronic cough <input type="checkbox"/>                         |
| Raspy voice quality <input type="checkbox"/>        | Vocal fatigue <input type="checkbox"/>                      | Halitosis <input type="checkbox"/>                             |
| Scratchy voice quality <input type="checkbox"/>     | Throat pain <input type="checkbox"/>                        | Worse voice when you wake <input type="checkbox"/>             |
| Shaky voice <input type="checkbox"/>                | Nasality <input type="checkbox"/>                           | Increased or chronic post nasal drip <input type="checkbox"/>  |
| Unsteady voice <input type="checkbox"/>             | Noisy breathing <input type="checkbox"/>                    | Tooth decay <input type="checkbox"/>                           |
| Voice breaks <input type="checkbox"/>               | Excessive throat mucus <input type="checkbox"/>             | Chronic bronchitis <input type="checkbox"/>                    |
| Pitch breaks <input type="checkbox"/>               | Foreign body sensation in throat <input type="checkbox"/>   |  |
| Voice too high <input type="checkbox"/>             | Heartburn <input type="checkbox"/>                          |  |
| Voice too low or deep <input type="checkbox"/>      | Indigestion <input type="checkbox"/>                        |  |
| Difficulty speaking loudly <input type="checkbox"/> |   |  |
| Difficulty speaking softly <input type="checkbox"/> |   |  |

- |   |  |
|---|--|
| Swallowing difficulty YES <input type="checkbox"/> NO <input type="checkbox"/>  | Injury (trauma) YES <input type="checkbox"/> NO <input type="checkbox"/>                     |
| Increased voice use YES <input type="checkbox"/> NO <input type="checkbox"/>  | Upper respiratory infection YES <input type="checkbox"/> NO <input type="checkbox"/>         |
| Emotional stress YES <input type="checkbox"/> NO <input type="checkbox"/>   | Surgery YES <input type="checkbox"/> NO <input type="checkbox"/>                             |
| Vocal Overuse (yelling/screaming) YES <input type="checkbox"/> NO <input type="checkbox"/>  | Surgery for voice related condition YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Around toxic fumes (gas, paint, chemicals) YES <input type="checkbox"/> NO <input type="checkbox"/>   | Recent Neck Injuries YES <input type="checkbox"/> NO <input type="checkbox"/>                |
| Similar voice problems in your past: YES <input type="checkbox"/> NO <input type="checkbox"/>   | It takes effort to speak: YES <input type="checkbox"/> NO <input type="checkbox"/>           |
| Voice has returned to normal ever: YES <input type="checkbox"/> NO <input type="checkbox"/>   | Problem worsens the more I talk: YES <input type="checkbox"/> NO <input type="checkbox"/>    |
| Does voice rest help your voice? YES <input type="checkbox"/> NO <input type="checkbox"/>   | Does anything help your voice? YES <input type="checkbox"/> NO <input type="checkbox"/>      |
| Can you be heard over ambient noise? YES <input type="checkbox"/> NO <input type="checkbox"/>   | Do others often ask you to repeat? YES <input type="checkbox"/> NO <input type="checkbox"/>  |
| Has the problem interfered with work? YES <input type="checkbox"/> NO <input type="checkbox"/>  | Upper body pain/tension? YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| Do you experience reflux symptoms? YES <input type="checkbox"/> NO <input type="checkbox"/>   | Do you treat your reflux symptoms? YES <input type="checkbox"/> NO <input type="checkbox"/>  |
| Choking or swallowing problems? YES <input type="checkbox"/> NO <input type="checkbox"/>  | Do you have pain when swallowing? YES <input type="checkbox"/> NO <input type="checkbox"/>   |
| My voice is worse in the: Morning <input type="checkbox"/> Evening <input type="checkbox"/>   | Seasonal changes affect my voice? YES <input type="checkbox"/> NO <input type="checkbox"/>   |
| Do you participate in fewer social activities since your current difficulty began? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |

1  
 Please attach a medication list to this Packet

**(Please See Reverse Side)**

\_\_\_\_\_  
 Patient Signature and Date

**Social History:**

I am  single  married  widowed  
Do you have children? YES  NO

Do you live alone? YES  NO   
Education  High School/GED  College

**General Medical Health:**

Arthritis <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	Depression <input type="checkbox"/>
Asthma (adult/childhood onset) <input type="checkbox"/>	Kidney/Bladder Disease <input type="checkbox"/>	Bleeding Problems <input type="checkbox"/>
Bronchitis <input type="checkbox"/>	Liver Disease <input type="checkbox"/>	Stroke <input type="checkbox"/>
Blood sugar (high/low) <input type="checkbox"/>	Lung Disease <input type="checkbox"/>	GI Disorders (hernia ulcers, colitis, etc.) <input type="checkbox"/>
Diabetes (adult/childhood onset) <input type="checkbox"/>	Joint/Bone Disease <input type="checkbox"/>	Sinus Disease <input type="checkbox"/>
Headaches <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>	Endocrine Disorder <input type="checkbox"/>
Heart disease <input type="checkbox"/>	Cancer <input type="checkbox"/>	Hearing Loss <input type="checkbox"/>
	Thyroid Disease <input type="checkbox"/>	Wear Hearing Aids <input type="checkbox"/>
	Neurologic Disorders <input type="checkbox"/>	

Other: \_\_\_\_\_

List Allergies: \_\_\_\_\_

*For females only:*

Are you pregnant? YES  NO  Have you gone through menopause? YES  NO   
Do you have regular menstrual cycles? YES  NO  Voice change during your menstrual cycle? YES  NO

**Vocal Use:**

Are you a "talker"? YES  NO  Do you clear your throat? YES  NO   
Do you cough? YES  NO  Do you sing? YES  NO   
Do you grunt when you exercise? YES  NO  Do you talk when you're stressed? YES  NO   
Do you talk when you are tired? YES  NO  Do you use the telephone often? YES  NO   
Do you talk for long periods with no break YES  NO  Do you scream YES  NO   
Do you do impersonations, character voices or unusual sound effects? YES  NO   
Do you talk when you are sick with any kind of upper respiratory infection? YES  NO   
Do you raise your voice (e.g. parenting, calling from room to room, etc)? YES  NO

**Vocal Hygiene:**

What is your current weight? \_\_\_\_\_ lbs  
Please list how much of the following you drink in ounces per day. 1 cup/glass = 8 oz.  
Water \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Soda \_\_\_\_\_ Energy Drinks \_\_\_\_\_ Milk \_\_\_\_\_ Juice \_\_\_\_\_  
Sports Drinks \_\_\_\_\_ Other (please specify) \_\_\_\_\_  
I drink alcoholic beverages  NEVER  daily  weekly  rarely ---- Beer \_\_\_ oz Wine \_\_\_ oz Liquor \_\_\_ oz  
I currently use tobacco products: YES  NO  ----- Cigarettes  Snuff  Vapor Cigarettes  Pipe   
How much (packs/cans/etc.) per day? \_\_\_\_\_ How many years? \_\_\_\_\_  
I have used tobacco products in the past? YES  NO  ----- Cigarettes  Snuff  Vapor Cigarettes  Pipe   
Packs/cans/etc. per day? \_\_\_\_\_ For how long? \_\_\_\_\_ years Date of Cessation \_\_\_\_\_  
Are you exposed to secondhand smoke? YES  NO  I use products containing menthol? YES  NO   
Do you take Vitamin C supplements? YES  NO  Do you use recreational drugs? YES  NO

## REFLUX SYMPTOM INDEX (RSI)

*PLEASE RATE HOW THE FOLLOWING PROBLEMS HAVE AFFECTED YOU WITHIN THE LAST MONTH, USING A ZERO-TO-FIVE SCALE, WHERE:*

***0= NO PROBLEM AND 5=SEVERE PROBLEM.***

- |  |             |
|--|-------------|
| 1. Hoarseness or a problem with you voice                                      | 0 1 2 3 4 5 |
| 2. Clearing your throat  | 0 1 2 3 4 5 |
| 3. Excess throat mucous or postnasal drip                                      | 0 1 2 3 4 5 |
| 4. Difficulty swallowing food, liquids or pills                                | 0 1 2 3 4 5 |
| 5. Coughing after you ate or after lying down                                  | 0 1 2 3 4 5 |
| 6. Breathing difficulties or choking episodes                                  | 0 1 2 3 4 5 |
| 7. Troublesome or annoying cough   | 0 1 2 3 4 5 |
| 8. Sensations of something sticking in your throat<br>or a lump in your throat | 0 1 2 3 4 5 |
| 9. Heartburn, chest pain, indigestion, or stomach<br>acid coming up            | 0 1 2 3 4 5 |

**TOTAL:** \_\_\_\_\_

*Belafsky PC, Postma GN, Koufman JA. Validity and reliability of the reflux symptom index (RSI).  
J Voice. 2002 Jun;16(2):274-7.*

# Voice Diagnostic Packet

## VOICE HANDICAP INDEX

Name: \_\_\_\_\_

Date: \_\_\_\_\_

- I need active use of my speaking voice primarily for
- A. my profession (teacher, minister, lawyer, etc)
  - B. activities outside work (coaching, community, etc)
  - C. normal everyday conversation

To be filled out by Voice Staff

P Spk   
NPV

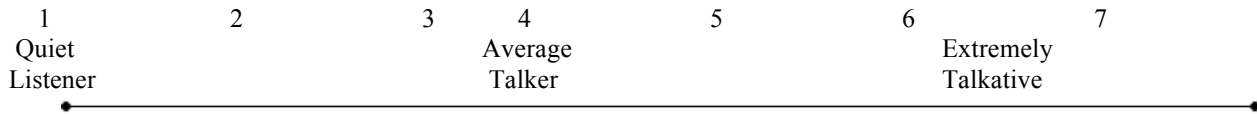
- I need active use of my singing voice primarily for:
- A. my profession (singer – primary income, student of voice)
  - B. activities outside work (choir/chorus, singer/band)
  - C. none of the above. I do not sing.

VHI F= \_\_\_\_\_  
P= \_\_\_\_\_  
E= \_\_\_\_\_

Total = \_\_\_\_\_

I would rate my degree of talkativeness as the following: (circle response)

P Sing   
R Sing



Instructions: These are statements that many people have used to describe their voices and the effects of their voices on their lives. Circle the response that indicates how frequently you have the same experience.

0=Never      1=Almost Never      2= Sometimes      3=Almost Always      4=Always

### Part I-F

- |  |           |
|--|-----------|
| 1. My voice makes it difficult for people to hear me.                            | 0 1 2 3 4 |
| 2. People have difficulty understanding me in a noisy room.                      | 0 1 2 3 4 |
| 3. My family has difficulty hearing me when I call them throughout the house.    | 0 1 2 3 4 |
| 4. I use the phone less often than I would like to.                              | 0 1 2 3 4 |
| 5. I tend to avoid groups of people because of my voice.                         | 0 1 2 3 4 |
| 6. I speak with friends, neighbors, or relatives less often because of my voice. | 0 1 2 3 4 |
| 7. People ask me to repeat myself when speaking face-to-face.                    | 0 1 2 3 4 |
| 8. My voice difficulties restrict personal and social life.                      | 0 1 2 3 4 |
| 9. I feel left out of conversations because of my voice.                         | 0 1 2 3 4 |
| 10. My voice problem causes me to lose income.                                   | 0 1 2 3 4 |

## Part II-P

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. I run out of air when I talk.                          | 0 | 1 | 2 | 3 | 4 |
| 2. The sound of my voice varies throughout the day.       | 0 | 1 | 2 | 3 | 4 |
| 3. People ask, "What's wrong with your voice?"            | 0 | 1 | 2 | 3 | 4 |
| 4. My voice sounds creaky and dry.                        | 0 | 1 | 2 | 3 | 4 |
| 5. I feel as though I have to strain to produce voice.    | 0 | 1 | 2 | 3 | 4 |
| 6. The clarity of my voice is unpredictable.              | 0 | 1 | 2 | 3 | 4 |
| 7. I try to change my voice to sound different.           | 0 | 1 | 2 | 3 | 4 |
| 8. I use a great deal of effort to speak.                 | 0 | 1 | 2 | 3 | 4 |
| 9. My voice is worse in the evening.                      | 0 | 1 | 2 | 3 | 4 |
| 10. My voice "gives out" on me in the middle of speaking. | 0 | 1 | 2 | 3 | 4 |

## Part III-E

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. I am tense when talking to others because of my voice. | 0 | 1 | 2 | 3 | 4 |
| 2. People seem irritated with my voice.                   | 0 | 1 | 2 | 3 | 4 |
| 3. I find other people don't understand my voice problem. | 0 | 1 | 2 | 3 | 4 |
| 4. My voice problem upsets me.                            | 0 | 1 | 2 | 3 | 4 |
| 5. I am less outgoing because of my voice problem.        | 0 | 1 | 2 | 3 | 4 |
| 6. My voice makes me feel handicapped.                    | 0 | 1 | 2 | 3 | 4 |
| 7. I feel annoyed when people ask me to repeat.           | 0 | 1 | 2 | 3 | 4 |
| 8. I feel embarrassed when people ask me to repeat.       | 0 | 1 | 2 | 3 | 4 |
| 9. My voice makes me feel incompetent.                    | 0 | 1 | 2 | 3 | 4 |
| 10. I am ashamed of my voice problem.                     | 0 | 1 | 2 | 3 | 4 |

*The Voice Handicap Index (VHI): Development and Validation  
Jacobsen B, Johnson A, Grywalski C, Silbergleit A, Jacobson G, Benninger M  
American Journal of Speech-Language Pathology, Vol 6(3), 66-70, 1997*

## Consent to Perform Videostroboscopy

Client Name: \_\_\_\_\_

I hereby consent to and authorize the performance of videostroboscopy for assessment of vocal fold structure and functioning to be performed at Fort Worth ENT.

*Initial:* \_\_\_\_\_

I consent to the administration of topical anesthetic, if required. I have no known allergies and/or medical conditions that prohibit the use of topical anesthetics.

*Initial:* \_\_\_\_\_

The nature and purpose of the procedures and the potential risks involved have been explained to me. Potential risks include allergic reaction to topical anesthetic, bleeding (transnasal endoscopy only), and/or temporary discomfort. No guarantee or assurance has been given by anyone as to the results that may be obtained.

*Initial:* \_\_\_\_\_

I understand that all information pertaining to services at Fort Worth ENT is kept confidential and will be made available to other professional personnel only after I have signed an Authorization to Send/Release Information form.

*Initial:* \_\_\_\_\_

Fort Worth ENT may participate in research and social media projects to expand knowledge of clinical outcomes in the treatment and evaluation of voice and voice disorders. Further, I understand that audio and/or videotapes of sessions and other case information may be used in these research projects. If I choose not to have my information included in research and social media projects, I do not have to initial here.

*Initial:* \_\_\_\_\_

\_\_\_\_\_  
*Signature of Client/Parent or Guardian*

\_\_\_\_\_  
*Date Signed*