Tanner Clinic Voice & Swallowing Center

Anna Siciliano, M.A., CCC-SLP
Laekin Clark, M.S. CCC-SLP
Lyssandra Harker, M.S., CCC-SLP
Megan Keate, M.A., CCC-SLP

Name: _____ DOB:_____ Age: _____

Referring Physician: _____

MEDICAL HISTORY (Please check all that apply):
Only fill out medications and medical history if you are new to Tanner Clinic or they are not previously noted

- ☐ Reflux
- ☐ Tremor
- ☐ Allergies
- ☐ Swallowing difficulty (Dysphagia)
- ☐ Hormone Imbalance
- ☐ Kidney Problems
- ☐ Respiratory Illness
- ☐ Stroke
- ☐ Esophageal Stretch/Dilation
- ☐ Lung Problems
- ☐ Headaches
- ☐ Colds
- ☐ Arthritis
- ☐ Head/Neck Cancer/Radiation
- ☐ Head Trauma/Brain Injury
- ☐ Pneumonia
- ☐ Asthma
- ☐ Intubations
- ☐ Heart Problems
- ☐ Depression
- ☐ Anxiety
- ☐ Eating disorders
- ☐ Rhinitis
- ☐ Parkinson's Disease
- ☐ Sleep apnea
- ☐ Pain (location:_____)

Surgery:

- ☐ None
- ☐ Carotid
- ☐ Cardiac
- ☐ Other:_____
- ☐ Head/Neck
- ☐ Laminectomy
- ☐ Lung
- ☐ Vocal folds/voice
- ☐ Thryoidectomy
- ☐ Hysterectomy

CURRENT MEDICATIONS:

Medication	Dosage	Purpose

Other Significant Accidents, Injuries, or Hospitalizations: None ☐

_____

_____

Please list physicians involved in your care and their role (ex. Dr. J, Pulomonogist)

_____

_____

My highest priority concern for today's visit is:

_____

_____

SOCIAL HISTORY & HABITS

☐ Married ☐ Divorced ☐ Single

Family at home:_____

Hobbies:_____

Do you use tobacco products? ☐ Yes ☐ No
If no, have you ever in the past? ☐ Yes ☐ No

Do you use any inhalants (smoking, vaping, etc.?) ☐ Yes ☐ No
If no, have you ever in the past? ☐ Yes ☐ No

If yes, list duration of years, amount and frequency per day:

_____

_____

Do you drink alcohol? ☐ Yes ☐ No
Do you drink caffeine? ☐ Yes ☐ No
Do you drink carbonation? ☐ Yes ☐ No
If yes to any above, list amount and frequency: _____

About how much water do you drink on a daily basis? _____ ounces

Do you exercise regularly? ☐ Yes ☐ No
Type of exercise:_____

How many hours do you sleep per night? _____hours
Sleep quality: ☐ Poor ☐ Average ☐ Good

Do you experience symptoms of reflux or heartburn? ☐ Yes ☐ No

About how many hours per day do you use your voice? _____hours

EMPLOYMENT:

Are you currently employed or in school? ☐ Yes ☐ No
If yes, where:_____

How do you use your voice in your occupation/at school/at home?

_____

_____

Do you experience a high level of stress at your job or in your home life? ☐ Yes ☐ No
If yes, please briefly describe:

_____

_____

How well do you feel that you cope with stressors in your life? ☐ Poorly ☐ Fine ☐ Well

Are there any topics that would be relevant to your care not yet mentioned (e.g. language, religion, food restrictions, cultural considerations, sexual orientation/gender identity, past trauma, etc.)?

Current Compliants:

Voice

When did your problem begin? _____ or I don't have a problem with this ☐
Was the onset ☐ sudden or ☐ graudal?
Is the problem ☐ worsening, ☐ improving, or ☐ staying the same?

My vocal behaviors include (select all that apply):

- ☐ Loud talking
- ☐ Singing
- ☐ Hard glottal attack
- ☐ Loud cheering
- ☐ Coughing
- ☐ Excessive talking
- ☐ Talked when stressed
- ☐ Using character voice/abnormal sounds
- ☐ Grunting with exercise
- ☐ Talking when tired
- ☐ Yelling/screaming
- ☐ Straining the voice
- ☐ Throat clearing
- ☐ Imitating noises
- ☐ Talking through colds
- ☐ Using too high/too low pitch

My throat sensations are (select all that apply):

- ☐ Dull pain
- ☐ Sharp pain
- ☐ Burning
- ☐ Globus (feel like there's something stuck in your throat)
- ☐ Throbbing
- ☐ Fatigue/tiredness
- ☐ Strained muscle

Breathing

When did your problem begin? _____ or I don't have a problem with this ☐
Was the onset ☐ sudden or ☐ graudal?
Is the problem ☐ worsening, ☐ improving, or ☐ staying the same?

Swallowing

When did your problem begin? _____ or I don't have a problem with this ☐
Was the onset ☐ sudden or ☐ graudal?
Is the problem ☐ worsening, ☐ improving, or ☐ staying the same?

Cough

When did your problem begin? _____ or I don't have a problem with this ☐
Was the onset ☐ sudden or ☐ graudal?
Is the problem ☐ worsening, ☐ improving, or ☐ staying the same?

Treatment Goals:

What are your expectations or goals from treatment?
Have you ever received speech therapy services before? ☐ Yes ☐ No

____/40 Total

Select the word that matches how serious you feel your breathing problem is **OVERALL**:
☐No Problem ☐Mild Problem ☐Moderate Problem ☐Severe Problem

Select the word that matches how serious you feel your breathing problem is **TODAY**:
☐No Problem ☐Mild Problem ☐Moderate Problem ☐Severe Problem

INSTRUCTIONS—
Please put an "X" in the box to indicate how often you feel these symptoms. Add up your score.

		Never (0)	Almost Never (1)	Some-times (2)	Almost Always (3)	Always (4)
1	**I have trouble getting air in.**	○	○	○	○	○
2	**I feel tightness in my throat when I am having my breathing problem.**	○	○	○	○	○
3	**It takes more effort to breathe than it used to.**	○	○	○	○	○
4	**Changes in weather affect my breathing problem.**	○	○	○	○	○
5	**My breathing gets worse with stress.**	○	○	○	○	○
6	**I make sound/noise breathing in.**	○	○	○	○	○
7	**I have to strain to breathe.**	○	○	○	○	○
8	**My shortness of breath gets worse with exercise or physical activity.**	○	○	○	○	○
9	**My breathing problem makes me feel stressed.**	○	○	○	○	○
10	**My breathing problem causes me to restrict my personal and social life.**	○	○	○	○	○
Totals						

Instructions: These are statements that many people have used to describe their voices and the effects of their voices on their lives. Check the response that indicates how frequently you have the same experience. (Never=0 points; Almost Never=1 Point; Sometimes=2 points; Almost Always=3 points; Always=4 points)

	Never	**Almost Never**	**Sometimes**	**Almost Always**	**Always**
F1. My voice makes it difficult for people to hear me.	○	○	○	○	○
P2. I run out of air when I talk.	○	○	○	○	○
F3. People have difficulty understanding me in a noisy room.	○	○	○	○	○
P4. The sound of my voice varies throughout the day.	○	○	○	○	○
F5. My family has difficulty hearing me when I call them throughout the house.	○	○	○	○	○
P6. I use the phone less often that I would like.	○	○	○	○	○
E7. I am tense when talking with others because of my voice.	○	○	○	○	○
F8. I tend to avoid groups of people because of my voice.	○	○	○	○	○
E9. People seem irritated with my voice.	○	○	○	○	○
P10. People ask, "What's wrong with your voice?"	○	○	○	○	○
F11. I speak with friends, neighbors, or relatives less often because of my voice.	○	○	○	○	○
F12. People ask me to repeat myself when speaking face-to-face.	○	○	○	○	○
P13. My voice sounds creaky and dry.	○	○	○	○	○
P14. I feel as though I have to strain to produce voice.	○	○	○	○	○
E15. I find other people don't understand my voice problem.	○	○	○	○	○
F16. My voice difficulties restrict my personal and social life.	○	○	○	○	○

	Never	Almost Never	Sometimes	Almost Always	Always
P17. The clarity of my voice is unpredictable.	○	○	○	○	○
P18. I try to change my voice to sound different.	○	○	○	○	○
F19. I feel left out of conversations because of my voice.	○	○	○	○	○
P20. I use a great deal of effort to speak.	○	○	○	○	○
P21. My voice is worse in the evening.	○	○	○	○	○
F22. My voice problem causes me to lose income.	○	○	○	○	○
E23. My voice problem upsets me.	○	○	○	○	○
E24. I am less out-going because of my voice problem.	○	○	○	○	○
E25. My voice makes me feel handicapped.	○	○	○	○	○
P26. My voice "gives out" on me in the middle of speaking.	○	○	○	○	○
E27. I feel annoyed when people ask me to repeat.	○	○	○	○	○
E28. I feel embarrassed when people ask me to repeat.	○	○	○	○	○
E29. My voice makes me feel incompetent.	○	○	○	○	○
E30. I am ashamed of my voice problem.	○	○	○	○	○

Total Score: _____

Please check the word that matches how you feel your voice is today:

☐ Normal ☐ Mild ☐ Moderate ☐ Severe

Name: DOB:

Treatment and Cancellation Policy

We highly value you as our patient. In an effort to help you make the most progress possible, we ask you to read this policy and discuss your thoughts with us as needed.

The Speech Pathologists are here part time and your appointment is important to us. We want to help you improve and make excellent progress

To help us in our efforts:

- Please keep your appointment, be on time, and bring your homework with you to each visit.
- Please complete exercises outlined by your therapist at home so you can make progress.
- **Please give us 48 hours notice for cancellations when possible. We want to see all patients that need help and last minute cancellations leave us with holes in our schedules.**
- **Patients that do not give 24 hours advanced notice may be charged a $50.00 cancellation fee. We make exceptions for emergencies and sudden illness.**
- Patients that cancel three appointments or no show may be asked to return to see their physician before another appointment can be scheduled.

We are passionate about helping our patients and we look forward to working together.

I have read and agree with the above policy.

_____

Name Date