Child Voice Case History

Child's Name _____ DOB _____ Age_____
Person Completing Form _____ Relationship_____
Referring Physician _____ Pediatrician/Family doctor_____
Please obtain a copy of your child's immunization record and attach to the case history.

Please explain the problem for which your child is being seen.
_____
_____

How long has your child's voice sounded this way? _____
Did the voice problem come on slowly or suddenly? _____

Check all that describe your child's voice.

___ hoarse
___breathy
___voice breaks/cracks
___harsh
___raspy
___frequently clears throat
___frequently yells/talks loudly
___frequently makes funny noises
___talks too softly
___talks too loudly
___frequently whispers
___deals with anger by yelling
___can't sing high notes
___complains that talking makes him/her tired
___voice worse in morning
___voice worse in evening
___complains of tickling/choking sensation
___frequent burping
___exposed to smoke
___voice sounds different from peers

Check all interpersonal skills your child exhibits.

___talks too much
___aggressive behavior
___poor self-esteem
___poor listening skills
___frequently cries
___doesn't take turns when talking
___doesn't respond to cues to change behavior
___always trying to get attention
___doesn't adapt behavior to situation
___temper tantrums

Medical Conditions
Does your child have now, or have a history of, any of the following?
(Please provide more information on those marked.)

___asthma _____
___allergies_____
___upper respiratory infections/conditions_____
___gastroesophageal reflux (GERD)/heartburn_____
___hearing loss_____
___frequent laryngitis_____
___frequent sore throats_____
___enlarged tonsils & adenoids_____
___other medical conditions_____

Has your child had any surgeries? Yes / No If yes, please list with dates:_____
_____

Medications

List any medications/supplements your child takes and what the medication is for:

Medications/Supplements	For
_____	_____
_____	_____
_____	_____

Has your child experienced any side effects/allergic reactions to novacaine while receiving dental work?_____
If yes, please explain_____

Hearing Acuity

When was the last time your child's hearing was tested?_____
What were the results of that evaluation?_____
Has your child been examined by an Ear, Nose and Throat doctor? Yes / No If yes, please list date(s) seen and the name and address of doctor(s): _____
_____

Extra-Curricular Activities

What extra-curricular activities is your child involved in? (Include hobbies, clubs, sports, etc.)
_____
_____

How often does he/she participate in these activities? _____
_____

Diet

How often does your child drink beverages or consume food with caffeine? (Include cola, tea, coffee, chocolate)
___never ___occasionally (1-3 per week) ___has at least 1 every day ___has more than 1 every day

What other types of beverages does your child drink? _____
Does your child eat a healthy diet? _____

List those residing in your household and their ages.

_____	_____	_____
_____	_____	_____

Is your child experiencing any pain today? Where?_____ Rate severity 1-10 _____

Please provide any other information pertinent to today's visit? _____
_____

The information provided by me above is current and accurate _____
Signature Date