TEXAS WOMAN'S UNIVERSITY
Department of Communication Sciences & Disorders
P.O. Box 425737, Denton, TX 76204-5737
Phone: (940) 898-2025 | Fax: (940) 898-2070

**VOICE CASE HISTORY
FOR ADULTS**

Date: _____/_____/______

General Information

Name:	
Date of Birth:	
Address:	
Phone:	
Occupation:	
Referred by:	
Primary Care Physician	
Marital status: Single _____ Widowed _____ Divorced _____ Married _____	

Who lives in the home?____

What languages do you speak? ____

If more than one language, which one is your dominant language?________________________

If married, do we have permission to discuss your care with your spouse? ☐ Yes ☐ No

Referral Information

Referred by: ____

Please attach reports from physicians(s), if applicable

Medical/Health History

Please check all that apply and provide additional information under comments.

CONDITION	CHECK (✓)	COMMENTS
Allergies		
Recurrent cold/sore throat		
Sinus infection		
Asthma		
Dizziness		
Dental problems		
Frequent laryngitis		
Epilepsy/seizure disorder		
Attention Deficit Hypertension Disorder (ADHD)		
Vision problems		
High fevers		
Influenza (Flu)		
Kidney problem		
Swallowing		
Reflux		
Other digestive disorders		
Respiratory difficulties		
Heart or circulatory problems		
Stroke		
Neurologic disorders		
Cancer		
Thyroid problems		
Adenoidectomy		
Tonsillectomy		
Draining ear		

Hearing issues		
Tinnitus		
Sleeping difficulties		
Other		

Do you have any eating or swallowing difficulties? ☐ Yes ☐ No If yes, please explain:

____

____

____

List all medications you are currently taking:______________________________

____

____

____

List all vitamins and herbal supplements you are currently taking: ________________

____

____

____

Are you experiencing any negative reactions/side effects to these medications? ☐ Yes ☐ No

If yes, please explain: ____

____

Have you had any serious illnesses? ☐ Yes ☐ No If yes, please explain: __________

____

____

Have you had any surgeries? ☐ Yes ☐ No If yes, please explain: ______________

____

____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____ for how many years? ________

Are you frequently around cigarette smoke? ☐ Yes ☐ No

How much water do you drink each day?___________________________________

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how many of these per day?_______

____

Do you drink coffee? ☐ Yes ☐ No If yes, how many cups per day? _______________

Do you do any weight training or heavy lifting? ☐ Yes ☐ No If so, how often?__________

____

How are you required to use your voice at work? ______________________________

Have you ever lost your voice? ☐ Yes ☐ No If yes, how many times? ______________

Please describe your general health. ______________________________________

____

____

____

____

____

Voice Issues

Please describe your voice problem.______________________________________

____

____

____

When did you first notice a change in your voice?_____________________________

How did the problem develop? ☐ Gradually ☐ Suddenly

Since it began, has the voice problem:

☐ gotten worse ☐ gotten better ☐ remained unchanged ☐ fluctuated

Describe if or how your changes:

When you talk a lot:____

When the weather changes: ______________________________________

With the time of day: ____

Does your voice change when you're feeling excitement, anger, anxiety? ☐ Yes ☐ No If yes, please explain: ____

____

Have people around you (family members, friends, and/or coworkers) noticed the voice issues?

____

What is your goal for speech therapy? ____

____

____

____

____

____

____

____

____

In the case of an emergency, please notify:

______________________________ ______________________________
Name and Relationship Contact Number

______________________________ ______________________________
Client Signature Date

Please complete the additional authorization forms that are attached. Once we have received this packet in our office, you will be contacted to schedule an evaluation and/or therapy.

If you have any questions, please contact the clinic at 940-898-2285. You may mail this packet to the address below, or you may fax it to 940-898-2276.

Mail to:
Texas Woman's University
Speech & Hearing Clinic – MCL 601
P.O. Box 425737
Denton, Texas 76204
Attn: D. Michele Stapleford

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Department of Communication Sciences & Disorders
P.O. Box 425737, Denton, TX 76204-5737
Phone: (940) 898-2285 | Fax: (940) 898-2276 | TTY: (940) 898-2019

Authorization for Evaluation/Treatment

I hereby authorize the following evaluations and/or treatments of ________________________________
(Please print clients' name)
in the Speech & Hearing Clinic at Texas Woman's University.

Please circle the choice(s) below

Speech/Language   Developmental/Feeding/Oral Motor   Audiological/Hearing

I hold the Speech & Hearing Clinic, Department of Communication Sciences, School of Occupational Therapy and Texas Woman's University harmless and waive any liability for injury, accident or illness to the client, caregivers, siblings, family members, or any other persons accompanying the client or family to the evaluation or therapy which may occur during or as the possible result of the course of evaluation/treatment.

I authorize that the evaluation and/or treatment procedures may be observed, videotaped, photographed, and discussed by students in disciplines related to the Speech & Hearing Clinic for academic, training, and advertising purposes. Furthermore, I authorize that the evaluation and/or treatment data may be used for research purposes as approved by appropriate University authorities.

It is my understanding that the examination findings and therapy reports will be treated as confidential materials and released only to such additional professional persons or agencies as I may authorize.

_________________   ____
Date   Please print name

____
Client or Parent/Guardian Signature

____
Address

____
City   State   Zip

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Disclosure Form

_________________________ _______________ __________
Patient Name (Please print) | Date of Birth | File#

Please read and initial in the space provided.

___________I understand that, by federal law, Texas Woman's University may not use or disclose my health information, except as provided in the University's Notice of Privacy Practices, without my authorization. My signature on this disclosure form indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release Texas Woman's University and its employees from any and all liability that may arise from the release of information as I have directed.

___________ I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing, and address it to the person or institution named above. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

___________ I understand that copies of the Speech, Language, and Hearing Clinics HIPPA Privacy Practices are available to me in the clinic office.

___________ I understand that I may refuse to sign this disclosure form. I also understand that the institution or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this disclosure form.

___________ I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected be the federal medical privacy law and could be disclosed by the person or agency that receives it.

This disclosure expires automatically upon ____
(Specify date, event, or one year from date of signature)

I have read and understand the information in this authorization form.

Signature of Patient or Legal Representative: ____

Please print name: _________________________________ Date: ___________________

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AUTHORIZATION FOR CONFIDENTIALITY

I authorize that the evaluation and/or treatment procedures and information regarding the same may need to be e-mailed back and forth between Texas Woman's University and the parent/guardians and between the supervisors and students. I authorize that this procedure may be used to further the understanding between clinical personnel and parent/guardian. Should I chose not to authorize this communication, students and supervisors will communicate via an in-house discussion board accessible only to personnel of the clinic, but will not use e-mail to communicate with me.

__________initial

I realize that the evaluation and/or treatment procedures might be observed in the room where the T.V. monitors are located or in the Lab room by other parents/guardians. Because of the use of earphones, they should not be able to hear the sessions. I understand that privacy will be observed as much as possible.

__________initial

I understand that I may revoke my permission at any time by communicating in writing with the clinical coordinator.

________________ ______________________________
Date Parent/Guardian Signature

____
Client's Name

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AUTHORIZATION FOR RECORDING AND USE OF EVALUATION/TREATMENT PROCEDURES

I hereby authorize that the evaluation/treatment procedures of___________________________
Clients' Name
may be recorded, videotaped, photographed, audio taped at the Department of Communication Sciences and Disorders at Texas Woman's University.

____
Initial

I authorize that the recorded evaluation/treatment procedure may be used for educational, research and advertising purpose both within and outside the University.

____
Initial

I authorize that the evaluation/treatment procedures may be observed and discussed, by student in disciplines related to the Department of Communication Sciences and Disorders for academics purposes.

____
Initial

Furthermore, I authorize that the evaluation/treatment data may be used for research purposes as approved by the appropriate University authorities.

____
Initial

I understand that the evaluation/treatment procedures will be treated confidential material and will be released only to additional professional persons or agencies as I may authorize.

____
Date

____
Client or Parent/Guardian Signature

____
Address

____
City State Zip