Santa Rosa Speech & Language Services
Jennifer Alwood, M.S., CCC-SLP
800 College Ave, Santa Rosa, CA 95404
Phone: 707-542-1010 Fax: 707-542-3232

Voice Intake Form

Date: _____
Name: _____ DOB: _____ Age: _____
Occupation: _____Parent(s)/Guardian(s): _____
Name of whom referred you to this office: _____

Please explain the problem for which you are being seen today.

_____
_____
_____

How long have you been experiencing this/these condition(s)? _____
Do you smoke? Examples: cigarette, marijuana, e-cigarettes or other substance. No ☐ Yes ☐
If yes, how much per week? _____
Do you drink? No ☐ Yes ☐ If yes, how much per week? _____
How much caffeine do you drink per day? _____
How much water do you drink per day? _____
Please list any medication(s) you are currently taking?

_____
_____
_____

Please circle if you currently experience or have a history of any of the following:

High Blood Pressure	Low Blood Pressure	Heart Attack
Stroke	Shortness of Breath	Asthma
Frequent bronchitis	Allergies	Heartburn/Reflux
Stomach Ulcers	Hiatal Hernia	TMJ
Hearing Loss	Dry Mouth	Dry Throat
Frequent Throat Clearing	Chronic Cough	Feeling of a "Lump" in Throat
Difficulty Swallowing	Frequent Laryngitis	Frequent Sore
Voice Change	Throat Tightness	Fatigue after Speaking
Difficulty getting Volume	Loss of Voice in Morning	Loss of Voice at Night
Upper Respiratory Condition Explain:	Cancer Explain:	Gastrointestinal Conditions Explain:

Have you ever been treated by an ENT (Ear Nose & Throat) physician? No ☐ Yes ☐
If yes, for what condition(s)? _____
Have you ever been treated by a speech-language pathologist? No ☐ Yes ☐
If yes, please explain. _____

Are you a singer? No ☐ Yes ☐ Have you received formal voice training in the past? No ☐ Yes ☐

Please list any major surgeries and approximate dates.

Surgery	Date

Other medical conditions not listed above: _____
_____
_____

Other changes related to your throat/voice: _____
_____
_____