

**Speech-Language-Hearing Center**

Founders Hall, Room 1300, Campus Box 1147

Edwardsville, IL 62026

(618) 650-5623 Fax: (618) 650-3307

CLIENT INFORMATION FORM

Transgender Voice

**PERSONAL INFORMATION**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widow/er

Relative/Significant Other Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROFESSIONAL INFORMATION**

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Do you use your voice as part of your professional duties?  □ No □ Yes If yes, how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Do you use your voice as a performer?  □ No □ Yes If yes, how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**If you are a singer**, please fill out the following section. If you are not a singer, skip to the next section:

|  |  |
| --- | --- |
| What is your voice type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What is your level of training (years of lessons, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What are your aspirations as a singer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | What is your style? □ Classical □ Pop/Rock  □ Musical Theater □ Church/Gospel  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How many hours each day/week do you spend:  in rehearsal? \_\_\_\_\_\_\_\_ in performance? \_\_\_\_\_\_\_\_ |

**VOICE PROBLEM(S)**

Please summarize your voice problem as briefly as possible \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your voice complaints (*What about it has changed? What won’t it do that it should or what does it do that it shouldn’t?*)

How long have you had the problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did it start: □ gradually or □ suddenly?

Was anything else going on in your life at the time of onset? (illness, yelling, stress, etc.?)

What makes it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Characteristics of your voice problem – check all that apply to you:

□ Voice is raspy □ Voice requires more effort □ Voice feels strained □ Cannot get loud

□ Worse in AM □ Worse in PM □ Uncomfortable to use voice □ Loss of high range

□ Loss of low range □ Decreased vocal endurance □ Pain in throat while using voice

□ Shortness of breath during speech □ Shortness of breath during exercise □ Stridor (noisy breathing)

How talkative are you, on a scale of 1 to 7? Check your answer based on your personality, not what your job requires of you:

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7

Quiet Listener Average Very talkative

Have you had a previous diagnosis and treatments?

**ADDITIONAL INFORMATION**

Other symptoms – check all that apply:

□ Trouble swallowing □ Pain with swallowing □ Throat clearing □ Coughing/choking while eating

□ Coughing □ Heartburn □ Dry/scratchy throat □ Feeling something stuck in throat

Have you ever been told that you have acid reflux or hiatal hernia? □ Yes □ No

Do you take an antacid medication? □ Yes □ No If yes, drug and dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine: How many cups of each do you have each day? coffee \_\_\_\_\_\_\_\_ tea \_\_\_\_\_\_\_ soda \_\_\_\_\_\_\_\_\_

Water: How many cups of water do you have each day? \_\_\_\_\_\_ Do you feel this is enough? □ Yes □ No

How often do you eat/drink tomato and citrus foods? □ Rarely □ Sometimes □ Frequently

**SOCIAL HISTORY**

Do you smoke? □ Yes □ No

If yes, packs per day? \_\_\_\_\_\_\_ Number of years? \_\_\_\_\_\_ Would you like to quit? □ Yes □ No

If no, did you smoke in the past? □ No □ Yes If yes, packs per day? \_\_\_\_\_ Number of years? \_\_\_\_\_\_ \_

Do you drink alcohol? □ Yes □ No

If yes, how many drinks do you have in an average week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, did you drink in the past? □ No □ Yes If yes, when did you stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take drugs? □ Yes □ No

If yes, what and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Please check any that apply:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Currently | | | In the Past | | |
|  | Yes | No | Unknown | Yes | No | Unknown |
| Gastrointestinal Reflux | □ | □ | □ | □ | □ | □ |
| Cancer | □ | □ | □ | □ | □ | □ |
| Asthma | □ | □ | □ | □ | □ | □ |
| Swallowing Disorder | □ | □ | □ | □ | □ | □ |
| Heart Condition | □ | □ | □ | □ | □ | □ |
| BPD | □ | □ | □ | □ | □ | □ |
| Other Pulmonary Disease | □ | □ | □ | □ | □ | □ |
| Hearing Loss | □ | □ | □ | □ | □ | □ |
| TMJ Problem | □ | □ | □ | □ | □ | □ |
| Vision Problems | □ | □ | □ | □ | □ | □ |
| Allergies | □ | □ | □ | □ | □ | □ |
| Thyroid Problems | □ | □ | □ | □ | □ | □ |
| Cleft Palate | □ | □ | □ | □ | □ | □ |
| Nasal Obstruction | □ | □ | □ | □ | □ | □ |
| Cold Sores (Fever Blisters) | □ | □ | □ | □ | □ | □ |
| Intubation | □ | □ | □ | □ | □ | □ |
| Tracheostomy | □ | □ | □ | □ | □ | □ |
| Lung or Breathing Problems | □ | □ | □ | □ | □ | □ |
| Rheumatoid Arthritis | □ | □ | □ | □ | □ | □ |
| Neck Pain or Lumps | □ | □ | □ | □ | □ | □ |
| Other (please specify):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ | □ | □ | □ | □ | □ |

Do you generally feel anxious of depressed? □ No □ Yes If yes, explain.

Have you ever been treated for anxiety or depression? □ No □ Yes If yes, explain.

Any other information that you feel is useful in relation to your voice:

**SPECIFIC QUESTIONS**

1. Are you under the care of a psychiatrist? \_\_\_\_ No \_\_\_\_Yes
2. Have you had surgical intervention? \_\_\_\_No \_\_\_\_Yes

Do you plan to have surgical intervention in the future? \_\_\_\_No \_\_\_\_Yes

1. Are you in a Gender Dysphoria Program? \_\_\_\_No \_\_\_\_Yes

What is your status within the program?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you ever change your voice in specific situations? \_\_\_\_No \_\_\_\_Yes

If so, how?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Which communication partners do you feel comfortable speaking with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you undergoing hormone treatment? \_\_\_\_No \_\_\_\_Yes

DIY treatments? \_\_\_\_No \_\_\_\_Yes Source?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If under hormone treatment, are there any side effects (calming, emotional lability, mental concentration)? Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What is the percentage of time spent in each gender role? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are you attending therapy as the mandatory prerequisite for approval for gender reassignment surgery? \_\_\_\_No \_\_\_\_Yes
4. Are you on any medications? \_\_\_\_No \_\_\_\_Yes

Do have any side effects? \_\_\_\_No \_\_\_\_Yes If so, please explain.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a support network and/or participate in social activity? \_\_\_\_No \_\_\_\_Yes

Please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is the status of employment and use of voice in employment setting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you have a specific vocal image in mind? Please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Who and/or what do you want your voice to sound like? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What are your personal goals (phone, social, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Have you been treated by an SLP in the past? \_\_\_\_No \_\_\_\_Yes

What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_