Voice Disorder Therapy Intake

Personal Information

Full Name

Date of Birth

Phone Number

Email Address

Address

Referral & History

How did you hear about our clinic?

Reason for referral / Main concern

Duration of symptoms

Previous diagnosis (if any)

Medical & Voice History

Relevant medical history (e.g., surgeries, illnesses)

Voice use (occupation, hobbies)

Onset and pattern of voice disorder

Factors that improve or worsen the condition

Current medications

Have you seen an ENT/laryngologist?

Voice & Communication Impact

How does your voice problem impact daily life?

Specific situations where you struggle the most

Therapy Goals

Your goals or expectations from therapy