Patient Intake Form
Adult Voice

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____
Street Address City State Zip

Phone #s: _____ _____
(home) (cell / work)

Email(s):_____

How did you hear about Arise Therapies, LLC? _____

Primary Care Provider (name and #): _____
Referred by PCP? ❑ Yes ❑ No

Other physicians: _____

_____

Primary insurance company: _____ ID #: _____

Primary insured name: _____ Relationship to patient: _____

Secondary insurance company: _____ ID #: _____

Secondary insured name: _____ Relationship to patient: _____

Family History: Please list any relevant family history (e.g., voice, neurological, allergies, GERD):

_____

Personal History:

Occupation: _____

Are you a high voice user? ❑ Yes ❑ No Please explain: _____

How are your stress levels? ❑ None ❑ Low ❑ Average ❑ High ❑ Very High

Please describe any past speech/voice therapy or vocal training: _____

_____

Any current concerns regarding hearing? _____

Primary concerns today: _____

_____

_____

(For office use only)
Date of evaluation: _____ *Diagnosis:* _____ *ICD10:* _____

Patient Name: _____

Vocal Hygiene

How much water do you drink per day? _____ How much caffeine? _____

Do you smoke? ❑ Yes ❑ No If yes, how much? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much per week? _____

Medical History

Do you have history of any of the following?

❑ Allergies	❑ Fatigue after speaking	❑ Loss of voice in morning
❑ Anxiety	❑ Feeling of "lump" in throat	❑ Loss of voice in night
❑ Asthma	❑ Frequent bronchitis	❑ Neurological
❑ Breathing difficulties	❑ Frequent laryngitis	❑ Parkinson's disease
❑ Chronic cough	❑ Frequent sore throats	❑ Shortness of breath
❑ Depression	❑ Frequent throat clearing	❑ Stroke
❑ Difficulty getting volume	❑ Head injury	❑ Swallowing difficulties
❑ Dry mouth	❑ Heart attack	❑ Throat tightness
❑ Dry throat	❑ Heartburn / reflux	❑ Voice change

Please list any other major hospitalizations / surgeries / medical concerns and approximate date(s):

_____

_____

Other changes related to your throat/voice: _____

_____

_____

Please list any medications you are currently taking with dosage: _____

_____

_____

Forms completed by: _____ Relationship to patient: _____

Patient Name: _____

Reflux Symptom Index

Within the last MONTH, how did the following problems affect you?

Hoarseness or a problem with your voice	0	1	2	3	4	5
Clearing your throat	0	1	2	3	4	5
Excess throat mucous	0	1	2	3	4	5
Difficulty swallowing food, liquids or pills	0	1	2	3	4	5
Coughing after eating or after lying down	0	1	2	3	4	5
Breathing difficulties or choking episodes	0	1	2	3	4	5
Troublesome or annoying cough	0	1	2	3	4	5
Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5

RSI TOTAL: (Therapist will total this information): _____