Voice
Student Input Form

Student's Name: **Date:**

Teacher's Name: Birth Date/Age:

Language spoken at home/school:

Please help me gain a better overall view of your voice skills by completing the information below.

Please answer by selecting N (Never), S (Sometimes), F (Frequently), AA (Almost Always)

1. Are you concerned about your voice being hoarse, raspy or nasal? If so, please describe

2. Do you lose your voice?

3. Do you participate in activities that require you to use a loud voice such as cheerleading or sports?

4. Are you ever embarrassed by your voice?

5. Do other people comment about your voice?

6. Rate your voice in the following situations:

	Better	Worse
Morning	☐	☐
Afternoon	☐	☐
Evening	☐	☐
Weekend	☐	☐

Spring	☐	☐
Summer	☐	☐
Winter	☐	☐
Fall	☐	☐
Home	☐	☐
School	☐	☐

7. Do you participate in the following activities or behaviors? Check all that apply.

- ☐ Sports that include shouting
- ☐ Excessive yelling/screaming
- ☐ Cheerleading
- ☐ Talking loudly
- ☐ Drug/alcohol use
- ☐ Choir or singing
- ☐ Clearing your throat or coughing a lot
- ☐ Cigarette smoking
- ☐ Excessive talking or arguing
- ☐ Exposure to allergens, e.g. dust, pollen, fumes, smoke

8. How does your voice difficulty impact you academically, socially, emotionally, and/or vocationally?