



# Transgender Voice and Communication Therapy - Case History Form

## General Information

Legal Name \_\_\_\_\_ Date \_\_\_\_\_

Preferred Name \_\_\_\_\_ Pronouns \_\_\_\_\_

Gender Identity \_\_\_\_\_ Sex Assigned at Birth \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

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

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Highest Level of Education Completed \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Native Language \_\_\_\_\_ Primary Language \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Referral Source / How did you hear about us? \_\_\_\_\_

Person Completing this Form \_\_\_\_\_ Relationship \_\_\_\_\_

## Additional Information

1. Do you ever change your voice in specific situations?  Yes  No  
If yes, how and in what situations? \_\_\_\_\_

2. Do you ever experience discomfort (e.g., strain, fatigue, dryness, "scratchy" voice, etc.)?  Yes  No  
If yes, please explain \_\_\_\_\_

3. Which communication partners do you feel most comfortable speaking with? \_\_\_\_\_

4. What situations and settings do you feel most comfortable speaking in? \_\_\_\_\_

5. Are you undergoing hormone treatment?  Yes  No  
If under hormone treatment, are there any side effects (calming, emotional liability, mental concentration, changes in voice, etc.)? Please explain. \_\_\_\_\_

6. Are you on any other medications?  Yes  No  
Do have any side effects?  Yes  No  
If yes, please explain. \_\_\_\_\_

7. What qualities do you like about your current voice? \_\_\_\_\_

8. What qualities do you dislike about your current voice? \_\_\_\_\_

9. What would you like to change about your current voice? \_\_\_\_\_

10. Who and/or what do you want your voice to sound like? \_\_\_\_\_

11. What are your personal goals for using your voice (phone, social, etc.)? \_\_\_\_\_

12. Have you been treated by an SLP in the past?  Yes  No

If yes, please describe your experience and/or results. \_\_\_\_\_