

Patient Intake for Tinnitus

Name _____
First MI Last

Preferred Name _____

Date of Birth _____ Age _____ Gender M F Self-Described

Your Mailing Address _____
Street City State Zip

Primary Phone _____ Home Cell Work Other

Email _____

Insurance _____ Insurance ID _____

Name of Primary Care Physician _____

Health History

What is your primary reason for coming in today? _____

Do you have a better hearing ear? R L Either

Have you experienced a sudden/progressive hearing loss in the last 90 days? R L Both Neither

Have you had any ear surgery? Yes No If yes, please explain _____

Do you suffer from ear pain or discomfort? Yes No Do you have any pressure in your ears? Yes No

Do you have any fullness/pressure in your ears? Yes No Do you notice ringing/sounds in your ears? Yes No

Do you have dizziness/vertigo? Yes No Do you have a history of ear drainage? Yes No

Have you been exposed to excessive noise in the last 16 hours? Yes No

Please review and check the following boxes:

I give permission to this practice to release information, verbal or written, contained in my medical record and other related information to my insurance company, health care providers, assignees and/or beneficiaries and all other related persons.

I allow for voice messages from this practice to be left on any provided phone number.

I acknowledge that I have had the opportunity to review a copy of The Hearing Solution's privacy notice. (Available in our office and on our website.)

I allow the following individuals (e.g., spouse/family members/caregivers) to be allowed access to my information regarding my hearing and ongoing treatments for the duration of my care, unless The Hearing Solution is notified otherwise.

I hereby authorize all benefits for charges of examination and/or treatments requested to be paid to The Hearing Solution. Verification of insurance coverage obtained over the phone does not guarantee payment. I have read this statement and accept full financial responsibility for all medical charges incurred by my dependents or me for services rendered by The Hearing Solution.

Signature of Patient, Parent or Legal Guardian

Date

Tinnitus Intake

Please answer the following groups of questions:

Have you ever:

Had any noisy jobs? Yes No

Had any noisy hobbies or home activities? Yes No

Used solvents, thinners or alcohol-based cleaners? Yes No

General Hearing Problems

Do you:

Have loose dentures, jaw pain or grinding or clicking sensations in your jaw? Yes No

Regularly take aspirin? Yes No

Have any feelings of ear pressure or blockage? Yes No

Have any difficulties hearing when there is background noise? Yes No

Have any difficulties understanding one-on-one conversations? Yes No

Have any difficulties hearing the TV? Yes No

Have any difficulties hearing on the telephone? Yes No

Wear ear protection/earplugs? Yes No

If so, how often and under what circumstances? _____

Find external sounds unpleasant or uncomfortable? Yes No

If so, please list _____

Effects of Your Tinnitus

Over the past week, what percentage of the time were you aware of your tinnitus? _____%

What percentage of the time was it disturbing? _____%

In which situations do you notice your tinnitus the most? _____

Describe the sound of your tinnitus (hissing, ringing, buzzing, etc.) _____

In which ear does your tinnitus occur? Left Right Both If both, in which ear is it worse? Left Right

Is your tinnitus: constant comes and goes

Does your tinnitus fluctuate in intensity or loudness? Yes No

What makes your tinnitus worse? _____

What makes your tinnitus better? _____

Do you find exposure to moderately loud sounds makes your tinnitus worse? Yes No

Does your tinnitus affect your sleep? Yes No

How has tinnitus affected your work life? _____

How has tinnitus affected your home life? _____

How has tinnitus affected your social activities? _____

Tinnitus History

When did you first become aware of your tinnitus, and what do you consider to have first started your tinnitus? _____

When did your tinnitus first become disturbing? Any specific situation? _____

Who have you consulted about your tinnitus? _____

What have you been told about your tinnitus? _____

What treatments have you tried for your tinnitus? None TRT Hearing Device Counseling Masker
 Music Therapy Other, please describe _____

How successful did you find these treatments? _____

Please rank the auditory problems you experience.

	Not Very Troublesome										Very Troublesome
Hearing Difficulties	1 2 3 4 5 6 7 8 9 10										
Tinnitus	1 2 3 4 5 6 7 8 9 10										
Sensitivity to Loud Sounds	1 2 3 4 5 6 7 8 9 10										

Are you pending any legal action? Yes No

List any medications you take for your tinnitus _____

List any other medications you take _____

Have you tried any medications in the past for your tinnitus? _____

Please list any medical evaluations and/or treatments related to your tinnitus (e.g., CT/MRI/psychological evaluation/etc.)

TINNITUS FUNCTIONAL INDEX

Today's Date _____

 Month / Day / Year

Your Name _____

 Please Print

Please read each question below carefully. To answer a question, select **ONE** of the numbers that is listed for that question, and draw a **CIRCLE** around it like this: **10%** or **1**.

I Over the PAST WEEK...

1. What percentage of your time awake were you consciously **AWARE OF** your tinnitus?

Never aware ► 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ◀ *Always aware*

2. How **STRONG** or **LOUD** was your tinnitus?

Not at all strong or loud ► 0 1 2 3 4 5 6 7 8 9 10 ◀ *Extremely strong or loud*

3. What percentage of your time awake were you **ANNOYED** by your tinnitus?

None of the time ► 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ◀ *All of the time*

SC Over the PAST WEEK...

4. Did you feel **IN CONTROL** in regard to your tinnitus?

Very much in control ► 0 1 2 3 4 5 6 7 8 9 10 ◀ *Never in control*

5. How easy was it for you to **COPE** with your tinnitus?

Very easy to cope ► 0 1 2 3 4 5 6 7 8 9 10 ◀ *Impossible to cope*

6. How easy was it for you to **IGNORE** your tinnitus?

Very easy to ignore ► 0 1 2 3 4 5 6 7 8 9 10 ◀ *Impossible to ignore*

C Over the PAST WEEK, how much did your tinnitus interfere with...

7. Your ability to **CONCENTRATE**?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◀ *Completely interfered*

8. Your ability to **THINK CLEARLY**?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◀ *Completely interfered*

9. Your ability to **FOCUS ATTENTION** on other things besides your tinnitus?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◀ *Completely interfered*

SL Over the PAST WEEK...

10. How often did your tinnitus make it difficult to **FALL ASLEEP** or **STAY ASLEEP**?

Never had difficulty ► 0 1 2 3 4 5 6 7 8 9 10 ◀ *Always had difficulty*

11. How often did your tinnitus cause you difficulty in getting **AS MUCH SLEEP** as you needed?

Never had difficulty ► 0 1 2 3 4 5 6 7 8 9 10 ◀ *Always had difficulty*

12. How much of the time did your tinnitus keep you from **SLEEPING** as **DEEPLY** or as **PEACEFULLY** as you would have liked?

None of the time ► 0 1 2 3 4 5 6 7 8 9 10 ◀ *All of the time*

Please read each question below carefully. To answer a question, select *ONE* of the numbers that is listed for that question, and draw a *CIRCLE* around it like this: **10%** or **1**.

A	Over the PAST WEEK, how much has your tinnitus interfered with...	<i>Did not interfere</i>	<i>Completely interfered</i>
	13. Your ability to HEAR CLEARLY ?	0 1 2 3 4 5 6 7 8 9 10	
	14. Your ability to UNDERSTAND PEOPLE who are talking?	0 1 2 3 4 5 6 7 8 9 10	
	15. Your ability to FOLLOW CONVERSATIONS in a group or at meetings?	0 1 2 3 4 5 6 7 8 9 10	
R	Over the PAST WEEK, how much has your tinnitus interfered with...	<i>Did not interfere</i>	<i>Completely interfered</i>
	16. Your QUIET RESTING ACTIVITIES ?	0 1 2 3 4 5 6 7 8 9 10	
	17. Your ability to RELAX ?	0 1 2 3 4 5 6 7 8 9 10	
	18. Your ability to enjoy " PEACE AND QUIET "?	0 1 2 3 4 5 6 7 8 9 10	
Q	Over the PAST WEEK, how much has your tinnitus interfered with...	<i>Did not interfere</i>	<i>Completely interfered</i>
	19. Your enjoyment of SOCIAL ACTIVITIES ?	0 1 2 3 4 5 6 7 8 9 10	
	20. Your ENJOYMENT OF LIFE ?	0 1 2 3 4 5 6 7 8 9 10	
	21. Your RELATIONSHIPS with family, friends and other people?	0 1 2 3 4 5 6 7 8 9 10	
	22. How often did your tinnitus cause you to have difficulty performing your WORK OR OTHER TASKS , such as home maintenance, school work, or caring for children or others? <i>Never had difficulty</i> ► 0 1 2 3 4 5 6 7 8 9 10 ◀ <i>Always had difficulty</i>		
E	Over the PAST WEEK...		
	23. How ANXIOUS or WORRIED has your tinnitus made you feel? <i>Not at all anxious or worried</i> ► 0 1 2 3 4 5 6 7 8 9 10 ◀ <i>Extremely anxious or worried</i>		
	24. How BOTHERED or UPSET have you been because of your tinnitus? <i>Not at all bothered or upset</i> ► 0 1 2 3 4 5 6 7 8 9 10 ◀ <i>Extremely bothered or upset</i>		
	25. How DEPRESSED were you because of your tinnitus? <i>Not at all depressed</i> ► 0 1 2 3 4 5 6 7 8 9 10 ◀ <i>Extremely depressed</i>		