Audiology Associates of Redding

Patient Intake

Name _____
First MI Last

Preferred Name _____

Date of Birth _____ Age _____ Gender ☐ M ☐ F

Your Mailing Address _____
Street City State Zip

Primary Phone _____ ☐ Home ☐ Cell ☐ Work ☐ Other

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 Audiology Associate'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 Audiology Associates is notified otherwise.

_____

☐ I hereby authorize all benefits for charges of examination and/or treatments requested to be paid to Audiology Associates of Redding. 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 Audiology Associates of Redding.

_____ _____
Signature of Patient, Parentor or Legal Guardian Date

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Audiology Associates of Redding

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? _____

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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.)

APPENDIX A

TINNITUS FUNCTIONAL INDEX

Today's Date _____ Your Name _____

Month / Day / Year *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...**	*Did not interfere*										*Completely interfered*
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...**	*Did not interfere*										*Completely interfered*
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...**	*Did not interfere*										*Completely interfered*
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?

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

E	**Over the PAST WEEK...**

23. How **ANXIOUS** or **WORRIED** has your tinnitus made you feel?

Not at all anxious or worried ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely anxious or worried*

24. How **BOTHERED** or **UPSET** have you been because of your tinnitus?

Not at all bothered or upset ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely bothered or upset*

25. How **DEPRESSED** were you because of your tinnitus?

Not at all depressed ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely depressed*