AUDIOLOGY ASSOCIATES
OF REDDING

Patient Intake

Name _____ Date _____
First MI Last

Preferred Name _____

Date of Birth _____ Age _____ Social Security Number _____

Gender ☐ M ☐ F Family/Primary Care Physician _____

Marital Status ☐ Single ☐ Divorced ☐ Widowed ☐ Married Spouse's Name _____

Your Mailing Address _____
Street City State Zip

Email _____ ☐ Okay to email

Primary Phone _____ ☐ Okay to text ☐ Home ☐ Cell ☐ Work ☐ Other

Cell Phone _____ ☐ Okay to text ☐ Home ☐ Cell ☐ Work ☐ Other

Occupation (past/present) _____ Retired? ☐ Yes ☐ No

How did you hear about us? _____

Health History

What is your primary reason for coming in today? _____

When was your last audiogram? _____ By whom? _____

How long ago did you notice your hearing decline? ☐ Within 1 Year ☐ 1-5 Years ☐ 6-10 Years ☐ 10+ Years

Which ear do you prefer to use on the phone? ☐ R ☐ L ☐ Either

Do you hear better in one ear? ☐ R ☐ L ☐ Neither

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 your ears produce excessive wax? ☐ Yes ☐ No

Do you have any pressure in your ears? ☐ Yes ☐ No

Do you have dizziness/vertigo? ☐ Yes ☐ No

Do you have a history of ear drainage? ☐ Yes ☐ No

Have you had chronic ear infections? ☐ Yes ☐ No

Have you had head trauma? ☐ Yes ☐ No

Family history of hearing loss? ☐ Yes ☐ No

Do you notice ringing/sounds in your ears? ☐ Yes ☐ No

Do you have a history of noise exposure? ☐ Occupational ☐ Recreational ☐ Military

Please list any current medications: _____

3328 Churn Creek Road, Suite A, Redding, CA 96002
Phone: (530) 221-7380 • Fax: (530) 221-7319 • www.besthearing.us

Hearing History

What environments or situations would you like to hear better in?

_____

Please rate your present hearing ability.

1 2 3 4 5 6 7 8 9 10

Perfect Hearing Severe Hearing Loss

Hearing Aid History

Have you worn hearing aids in the past? ☐ Yes ☐ No

How long? _____

List any major problems or concerns you have with your current hearing aid(s).

_____

Are you interested in hearing aids with Bluetooth® compatibility? ☐ Yes ☐ No

Are you interested in rechargeable hearing aids? ☐ Yes ☐ No

Please rate how motivated you are to use hearing aids.

1 2 3 4 5 6 7 8 9 10

Not very Very

Confidentiality and Right to Bill Agreement

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.

☐ On occasion, Audiology Associates of Redding sends out newsletters or birthday cards. I allow Audiology Associates of Redding to contact me by mail or e-mail about new information or specials.

☐ I acknowledge that I have had the opportunity to review a copy of Audiology Associates of Redding'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 their care unless Audiology Associates of Redding 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.

☐ I acknowledge that any co-pays or deductibles are my responsibility and are due at the time services are rendered. It is Audiology Associates of Redding's policy to send accounts that are overdue by 90 days to collections.

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, 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: _____

Please list any known health conditions: _____

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 bothersome? _____%

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: _____

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 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% ◀ *All of the time*

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 1 2 3 4 5 6 7 8 9 10 ◀ *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?

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

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*

APPENDIX A

TINNITUS FUNCTIONAL INDEX

Please read each question below carefully. To answer a question, select ONE of the numbers 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, schoolwork 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*