Designer Audiology

Patient Registration Form

- ☐ New patient registration
- ☐ Update of current patient demographic information

Demographic Information

Patient Name: _____ Date of Birth: _____

Date of Completion: _____ Preferred Name: _____ Birth Gender (circle one): Male Female

Gender (circle one): Male Female Transgender Male-to-Female Transgender Female-to-Male

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Primary Contact (circle one): Home Work Cell Email Text

Appointment Reminders (circle all that apply): Home Work Cell Email Text

If child, please list the name of the custodial parents/guardians: _____

_____

Marital Status (circle one): Single Married Separated Divorced Widowed Domestic Partner

Name of Spouse/Partner, if applicable: _____

Current Employment Status (circle one): Full-time Part-time Retired Unemployed Stay at Home Parent Student

Current Employer: _____

Occupation: _____

Highest Level of Education Completed: _____

Social Security Number: _____

Spoken Language (complete all that apply): English Spanish Other: _____

Race (circle one): American-Indian Asian African American Pacific Islander White Other: _____

Ethnicity (circle one, if applicable): Hispanic Latino

Emergency Contact Information

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

DESIGNER AUDIOLOGY, LLC WILL MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD FOR OUR RECORDS AND VERIFY YOUR IDENTITY TO PREVENT HEALTHCARE FRAUD. PLEASE BRING ALL INSUANCE CARDS AND A GOVERNMENT-ISSUED PHOTO ID WITH YOU TO THE APPOINTMENT.

CONTINUED

Insurance Information

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Effective Date: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Effective Date: _____

Guarantor/Responsible Party/Name of Insured: _____

Social Security Number of Responsible Party/Insured: _____

Date of Birth of Responsible Party/Insured: _____

Address of Guarantor: _____

Physician Information

Referring Physician Name: _____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

Would you like Designer Audiology, LLC to send a copy of your current and future test results and/or reports to (please check all that apply; by checking the box and listing names below, you are authorizing Designer Audiology, LLC to communicate with these entities regarding your healthcare and treatment):

- □ Referring Physician
- □ Primary Care Physician (PCP)
- □ Other Physician, please specify: _____
- □ School, please specify: _____
- □ Family Member(s)/Guardian(s), please specify: _____
- □ Other: _____
- □ None (self-pay option only)

How did you hear about Designer Audiology, LLC? (Please check **all** that apply):

☐ Designer Audiology, LLC Facebook Page ☐ Designer Audiology, LLC Website

☐ Designer Audiology, LLC Sign ☐ Health Fair Event ☐ Open House

☐ Internet/Search Engine, please specify which one: _____

☐ Family Member/Friend, please provide full name so Designer Audiology, LLC may thank him/her for the referral:_____

☐ Doctor, please specify: _____

☐ Phone book, please specify which one:_____

☐ Direct Mail Piece, please specify which one: _____

☐ Newspaper, please specify which one: _____

☐ Other: _____

_____

CONTINUED

Signature Information

_____ (initial here) By initialing this section and signing below, I acknowledge that I received a copy of Designer Audiology, LLC's Notice of Privacy Practices. The Notice provides information about how Designer Audiology, LLC may use and disclose the medical information that is maintained about you. Designer Audiology, LLC encourages you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website, and that any revised Notice of Privacy Practices will be made available upon request.

_____ (initial here) By initialing this section and signing below, I authorize Designer Audiology, LLC to send me educational and/or marketing information on the products and services offered by Designer Audiology, LLC. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ (initial here) By initialing this section and signing below, I agree to accept the financial policies of Designer Audiology, LLC. I understand that payment in-full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

_____

Signature of patient or custodial parent/guardian Date

_____

Printed name of patient or custodial parent/guardian Date

Designer Audiology

Office and Financial Policies

Patient Name: _____ Date of Birth: _____

Date: _____ Phone Number: _____

Address: _____

Thank you for choosing Designer Audiology, LLC for your hearing and balance healthcare needs. We are committed to you and your improved hearing and balance. We also want your experience with us to be a positive and productive one. To that end, we want to take this opportunity to inform our patients and their families of our payment policies. This knowledge will help you be better prepared for your appointment.

Designer Audiology, LLC is a participating provider with many insurance carriers in the area. We can assist you in determining whether or not we are a participating provider for your insurance plan.

Insurance coverage is an agreement between you and your insurance carrier. We, as healthcare providers, just execute that agreement for you. As a result, it is your responsibility to determine whether or not you have out-of-network benefits (if Designer Audiology, LLC is not a participating provider in your insurance plan), if you require prior authorization or a referral prior to services being provided, or if audiology services and/or hearing aids are covered through your plan. It is important to gather this information prior to your appointment with us. Designer Audiology, LLC cannot submit a claim to any insurance carrier if we do not have all required orders, referrals, or prior authorizations on file. They cannot be obtained after the service is provided. If you are unsure of your coverage specifics, please bring your member benefits handbook with you to the appointment.

Insurance carriers do not cover, in-full, all goods and services. While we will verify coverage specifics with your insurance carrier as needed, please understand that these are NOT a guarantee of coverage or payment. There may be situations where your insurance carrier does not cover the specific good or service you are requesting. Designer Audiology, LLC commits to providing quality, professional hearing and balance healthcare to all its patients, regardless of their circumstance. When required and possible, we will work to offer an item or service that is within the limits of your insurance coverage.

It is very important that you inform us within 24 hours of your appointment if you need to cancel or reschedule. While we realize that emergencies do occur, Designer Audiology, LLC reserves the right to charge a $100 cancellation fee for all no-show appointments or appointments cancelled with less than a 24 hour notice.

We understand that sometimes you may be running late to your appointment. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 15 minutes after your scheduled appointment time. We will try to accommodate you, if time allows. Otherwise, we will need for you come back later in the day, if a later appointment is available, or reschedule to another date and time.

Payment in-full is due at the time the services are provided. You are responsible to pay all out-of-pocket expenses, such as co-pays, co-insurance, and deductibles on the date the service is provided. All hearing aid related charges must be paid on the date you take possession of the aid, accessory, or supply.

Designer Audiology, LLC accepts payment in the form of cash, checks, American Express, Visa, MasterCard, and Discover credit card. We also offers a third-party credit program through AllWell. There will be a $50 fee for all bounced or returned checks.

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It is also the policy of Designer Audiology, LLC that we may maintain a credit card number on file. This allows us to bill you for an outstanding balance that is not collected within 90 days of the date you were initially billed, while continuing to provide you with care. We will not bill any charge to your credit card without first informing you of this in writing. You then have the right to use an alternate form of payment, if you so choose.

It is important that each patient accepts and meets their financial obligations to this practice. Otherwise, we will be unable to provide care to any of our patients. Designer Audiology, LLC reserves the right, following 90 days of the initial invoice date, to forward all outstanding balances to either a third-party collection agency and/or small claims court. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to us.

I understand if I have an unpaid balance to Designer Audiology, LLC and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Designer Audiology, LLC or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Designer Audiology, LLC and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

_____

Signature of patient or personal representative Date

Designer Audiology

Notice of Privacy Practices

This notice described how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

ABOUT THIS NOTICE

Designer Audiology, LLC is committed to protecting your health information. This Notice of Privacy Practices ("Notice") is provided pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as revised in the 2013 HIPAA Omnibus Rule. This Notice describes how Designer Audiology, LLC may use and disclose your protected health information to carry out treatment, payment or audiologic/health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights and Designer Audiology, LLC's duties with respect to your protected health information.

"Protected health information" is information about you that may identify you and that relates to your past, present, or future physical or mental health/condition and related audiologic/health care services. Designer Audiology, LLC must follow the privacy practices that are described in this Notice while it is in effect. If you have any questions about this Notice, please contact our Privacy Officer and/or Owner, Dr. Alicia D.D. Spoor, Owner, at (443) 410-4410 or Alicia.Spoor@DesignerAudiology.com.

HOW DESIGNER AUDIOLOGY, LLC MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe the different ways that Designer Audiology, LLC may use and disclose your protected health information. These examples are not meant to be exhaustive, but to illustrate the types of uses and disclosures that may be made.

Treatment

Designer Audiology, LLC may use and disclose your protected health information to provide, coordinate, or manage your audiologic treatment and any related services. Designer Audiology, LLC may also disclose your protected health information to other third party providers involved in your audiologic/health care. For example, your protected health information may be provided to a physician or other audiologic/health care provider (e.g. a specialist or laboratory) to whom you have been referred to ensure that the physician or other audiologic/health care provider has the necessary information to diagnose or treat you.

Payment

Designer Audiology, LLC may use and disclose your protected health information so that the treatment and health care services you receive may be billed to you, your insurance company, a government program, or third party payers. This may include certain activities that your health insurance plan may undertake before it approves or pays for the audiologic/health care services Designer Audiology, LLC recommends for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, Designer Audiology, LLC may provide your health plan with medical information about the audiologic/health care services Designer Audiology, LLC rendered to you for reimbursement purposes.

CONTINUED

Audiological/Health Care Operations
Designer Audiology, LLC may use and disclose your protected health information for audiologic/health care operation purposes. These uses and disclosures are necessary to make sure that all patients receive quality care and for operation and management purposes. For example, Designer Audiology, LLC may use your protected health information to review the quality of the treatment and services you receive and to evaluate the performance of Designer Audiology, LLC's team members in caring for you. Designer Audiology, LLC also may disclose information to audiologists, physicians, nurses, technicians, medical students, and other personnel for educational and learning purposes.

Treatment Communications
Designer Audiology, LLC may provide treatment communications concerning treatment alternatives or other health related products or services. For communications for which Designer Audiology, LLC or a business associate may receive financial remuneration in exchange for making the communication, Designer Audiology, LLC must obtain written authorization unless the communication is made face-to-face and/or involving promotional gifts of nominal value. If you do not wish to receive these communications please submit a written request to our Privacy Officer and/or Owner, Dr. Alicia D.D. Spoor, Owner, Designer Audiology, LLC 13364A Clarksville Pike Highland, MD 20777.

Fundraising Activities
Designer Audiology, LLC may use or disclose your demographic information and dates of services provided to you, as necessary, in order to contact you for fundraising activities supported by Designer Audiology, LLC. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to our Privacy Officer and/or Owner, Dr. Alicia D.D. Spoor, Owner, Designer Audiology, LLC 13364A Clarksville Pike Highland, MD 20777.

Others Involved in Your Healthcare
Unless you object, Designer Audiology, LLC may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, Designer Audiology, LLC may disclose such information, as necessary, if Designer Audiology, LLC determines that it is in your best interest based on professional judgment. Also, for example, if you are brought into this office and are unable to communicate normally with your clinician for some reason, Designer Audiology, LLC may find it is in your best interest to give your hearing instrument and other supplies to the friend or relative who brought you in for treatment. Designer Audiology, LLC may also use and disclose protected health information to notify such persons of your location, general condition, or death. Designer Audiology, LLC also may coordinate with disaster relief agencies to make this type of notification. Designer Audiology, LLC also may use professional judgment and experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up your hearing instruments, supplies, records, or other things that contain protected health information about you.

Required by Law
Designer Audiology, LLC may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health
Designer Audiology, LLC may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Designer Audiology, LLC may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

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Business Associates
Designer Audiology, LLC may disclose your protected health information to business associates that perform functions on Designer Audiology, LLC's behalf or provide Designer Audiology, LLC with services if the information is necessary for such functions or services. To protect your health information, however, Designer Audiology, LLC require the business associate to appropriately safeguard your information.

Communicable Diseases
Designer Audiology, LLC may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight
Designer Audiology, LLC may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies
seeking this information include government agencies that oversee the audiologic/health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect
Designer Audiology, LLC may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, Designer Audiology, LLC may disclose your protected health information if Designer Audiology, LLC believes that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration
Designer Audiology, LLC may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

Legal Proceedings
Designer Audiology, LLC may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement
Designer Audiology, LLC may disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

Coroners, Funeral Directors, and Organ Donation
Designer Audiology, LLC may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. Designer Audiology, LLC may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out its
duties. Designer Audiology, LLC may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

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Research
Designer Audiology, LLC may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Serious Threat to Health or Safety
Consistent with applicable federal and state laws, Designer Audiology, LLC may disclose your protected health information to prevent or lessen a serious threat to your health and safety, or to the health and safety of another person or the public.

Military Activity and National Security
If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, Designer Audiology, LLC may disclose your protected health information to authorized officials so they may carry out their legal duties under the law.

Workers' Compensation
Designer Audiology, LLC may disclose your protected health information as authorized for workers' compensation or other similar programs that provide benefits for a work-related illness.

For Data Breach Notification Purposes
Designer Audiology, LLC may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.

Required Uses and Disclosures
Under the law, Designer Audiology, LLC must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH AND GENETIC INFORMATION
Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this Notice may not apply to these types of information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION
The following uses and disclosures will be made only with your written authorization:

- Uses and disclosures of protected health information for marketing purposes for which Designer Audiology, LLC or a business associate may receive remuneration; and
- Disclosures that constitute a sale of protected health information.

Other uses and disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that Designer Audiology, LLC has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health information described above in this Notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.

CONTINUED

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Right to be Notified if there is a Breach of Your Protected Health information

You have the right to be notified upon a breach of any of your unsecured protected health information.

Right to Inspect and Copy

You may inspect and obtain a copy of your protected health information that is contained in your medical and billing records and any other records that Designer Audiology, LLC uses for making decisions about you. To inspect and copy your medical information, you must submit a written request to our Privacy Officer and/or Owner, Dr. Alicia D.D. Spoor, Owner, Designer Audiology, LLC 13364A Clarksville Pike Highland, MD 20777. If you request a copy of your information, Designer Audiology, LLC may charge you a reasonable fee for the costs of copying, mailing or other costs incurred in complying with you request. Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, Designer Audiology, LLC may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our Privacy Officer and/or Owner, Dr. Alicia D.D. Spoor, Owner, at (443) 410-4410 or Alicia.Spoor@DesignerAudiology.com if you have questions about access to your medical record.

Right to Request Restrictions

You may ask Designer Audiology, LLC not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. To request a restriction on who may have access to your protected health information, you must submit a written request to our Privacy Officer and/or Owner, Dr. Alicia D.D. Spoor, Owner, Designer Audiology, LLC 13364A Clarksville Pike Highland, MD 20777. Your request must state the specific restriction requested and to whom you want the restriction to apply. Designer Audiology, LLC is not required to agree to a restriction that you may request, unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or audiologic/health care operation purposes and such information you wish to restrict pertains solely to an audiologic/health care item or service for which you have paid Designer Audiology, LLC "out-of-pocket" in- full. If Designer Audiology, LLC believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If Designer Audiology, LLC does agree to the requested restriction, Designer Audiology, LLC may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

Right to Request Confidential Communication

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. Designer Audiology, LLC will accommodate reasonable requests. You must request this by submitting a written request to our Privacy Officer and/or Owner, Dr. Alicia D.D. Spoor, Owner, Designer Audiology, LLC 13364A Clarksville Pike Highland, MD 20777.

Right to Request Amendment

You may request an amendment of your protected health information contained in your medical and billing records and any other records that Designer Audiology, LLC uses for making decisions about you, for as long as Designer Audiology, LLC maintains the protected health information. You must request for an amendment by submitting a written

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request to our Privacy Officer and/or Owner, Dr. Alicia D.D. Spoor, Owner, Designer Audiology, LLC 13364A Clarksville Pike Highland, MD 20777, and provide the reason(s) that support your request. In certain cases, Designer Audiology, LLC may deny your request for an amendment. If Designer Audiology, LLC denies your request for an amendment, you have the right to file a statement of disagreement with Designer Audiology, LLC and Designer Audiology, LLC may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures

You have the right to receive an accounting of certain disclosures Designer Audiology, LLC has made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice. It excludes disclosures Designer Audiology, LLC may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. You must request for an accounting of disclosures by submitting a written request to our Privacy Officer and/or Owner, Dr. Alicia D.D. Spoor, Owner, Designer Audiology, LLC 13364A Clarksville Pike Highland, MD 20777, and provide the reason(s) that support your request.

Right to Obtain a Paper Copy of this Notice

You have the right to receive a paper copy of this Notice even if you have agreed to receive this notice electronically. You may ask Designer Audiology, LLC to give you a copy of this notice at any time. To obtain a paper copy of this Notice, you can contact our Privacy Officer and/or Owner, Dr. Alicia D.D. Spoor, Owner, at (443) 410-4410 or Alicia.Spoor@DesignerAudiology.com. You may also obtain a copy of this Notice at www.DesignerAudiology.com.

COMPLAINTS OR QUESTIONS

If you believe your privacy rights have been violated, you may file a complaint with Designer Audiology, LLC or with the Secretary of the U.S. Department of Health and Human Services. If you have a question about this Notice or wish to file a complaint with Designer Audiology, LLC, please contact our Privacy Officer and/or Owner, Dr. Alicia D.D. Spoor, Owner, at (443) 410-4410 or Alicia.Spoor@DesignerAudiology.com or the Corporate Privacy Officer at the address listed below. All complaints must be submitted in writing. Designer Audiology, LLC will not retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE

Designer Audiology, LLC reserves the right to change this Notice at any time. The new Notice will be effective for all health information Designer Audiology, LLC already has about you as well as any information received in the future. You can also obtain a revised Notice at www.DesignerAudiology.com or by contacting our Privacy Officer and/or Owner, Dr. Alicia D.D. Spoor, Owner, Designer Audiology, LLC 13364A Clarksville Pike Highland, MD 20777.

Designer Audiology
Attn: Corporate Privacy Officer
13364A Clarksville Pike
Highland, MD 20777

This Notice is effective as of April, 2013.

Designer Audiology

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

Date: _____ Phone Number: _____

Address: _____

I acknowledge that I received a copy of Designer Audiology, LLC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, on the website, and that I will be given a copy of any amended Notice of Privacy Practices upon request.

- This Notice informs me how Designer Audiology, LLC will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Designer Audiology, LLC may use and share my health information for other than treatment, payment, and health care operations.
- Designer Audiology, LLC will also use and share my health information as required/permitted by law.

_____

Signature of patient or personal representative Date

Designer Audiology

Tinnitus Case History Form

Patient Name: _____ Date of Birth: _____

Date: _____ Phone Number: _____

Address: _____

Gender (circle one): Male Female

Current Tinnitus

Where do you perceive your tinnitus: (check one) ☐Right ear ☐Left ear ☐Both ears equally

☐Both ears, worse in the right ☐Both ears, worse in the left ☐Center of Head ☐Other: _____

Is your current tinnitus: (check one) ☐Constant ☐Intermittent, explain: _____

What does your tinnitus sound like: _____

_____

Is there a secondary tinnitus sound: (check one) ☐Yes ☐No

If so, what does it sound like: _____

_____

What percentage of the time are you:

Aware of your tinnitus: _____% Bothered by your tinnitus: _____%

How has the percentage of the time you are bothered by your tinnitus changed since you first noticed it: (check one)

☐Increased ☐No change ☐Decreased

When is the tinnitus most bothersome: (check one) ☐At night ☐In the morning ☐After work

☐With caffeine consumption ☐With alcohol consumption ☐When tired ☐When tense/stressed

☐When relaxed ☐While working ☐During social activities

☐Around noise ☐When trying to concentrate ☐ Other: _____

When is the tinnitus least bothersome: (check one) ☐At night ☐In the morning ☐After work

☐With caffeine consumption ☐With alcohol consumption ☐When tired ☐When tense/stressed

☐When relaxed ☐While working ☐During social activities

☐Around noise ☐When trying to concentrate ☐ Other: _____

Does the tinnitus prevent you from falling asleep: (check one) ☐Yes ☐No

Does the tinnitus wake you up at night: (check one) ☐Yes ☐No

0 1 2 3 4 5 6 7 8 9 10

None Mild Moderate Severe Excruciating

Using the above scale, indicate the loudness of your tinnitus:

_____ Right now _____On average _____ At its worst _____ At its least

CONTINUED

Does the loudness of your tinnitus: (check one)

☐stay constant day to day ☐fluctuate greatly day to day ☐occasionally decreases significantly

☐occasionally increases significantly

0 1 2 3 4 5 6 7 8 9 10

Low-Pitch Mid-Pitch High-Pitch

Using the above scale, circle the pitch of your tinnitus.

0 1 2 3 4 5 6 7 8 9 10

Not bothered Mildly Moderately Severely Extremely

Are you currently bothered by your tinnitus: (circle the best number)

What have you tried to suppress the tinnitus: (check all that apply)

☐Acupuncture ☐Biofeedback ☐Cochlear Implant(s)

☐Cognitive Behavioral and Mindfulness Based Stress Reduction ☐Diet Change(s)

☐Earplug(s) ☐Exercise ☐Hearing Aid(s)

☐Sound therapy/Hearing masker(s) ☐TMJ Treatment

☐Transcranial Magnetic Stimulation

☐Surgery- explain: _____

☐Drug Therapy- List: _____

_____

Which options helped suppress the tinnitus: (check all that apply)

☐Acupuncture ☐Biofeedback ☐Cochlear Implant(s)

☐Cognitive Behavioral and Mindfulness Based Stress Reduction ☐Diet Change(s)

☐Earplug(s) ☐Exercise ☐Hearing Aid(s)

☐Sound therapy/Hearing masker(s) ☐TMJ Treatment

☐Transcranial Magnetic Stimulation

☐Surgery- explain: _____

☐Drug Therapy- List: _____

_____

Which options made the tinnitus worse: (check all that apply)

☐Acupuncture ☐Biofeedback ☐Cochlear Implant(s)

☐Cognitive Behavioral and Mindfulness Based Stress Reduction ☐Diet Change(s)

☐Earplug(s) ☐Exercise ☐Hearing Aid(s)

☐Sound therapy/Hearing masker(s) ☐TMJ Treatment

☐Transcranial Magnetic Stimulation

☐Surgery- explain: _____

☐Drug Therapy- List: _____

_____

CONTINUED

Does head/neck movement change the tinnitus: (check one) ☐Yes ☐No

If so, does movement make the tinnitus: (check one) ☐Less noticeable ☐More noticeable

Have you seen another healthcare professional for the tinnitus: (check one) ☐Yes ☐No

If so, who and when: (check all that apply)

☐Primary Care Physician: _____

☐Naturopathic Physician: _____

☐Ear, Nose, and Throat (ENT) Physician: _____

☐Neurologist: _____

☐Audiologist: _____

☐Other: _____

Do you feel emotional or physical stress when the tinnitus is present: (circle one) ☐Yes ☐No

If so, when is it worse: _____

_____

Have you discussed the tinnitus with family, friends, and/or doctors/professionals: (check one) ☐Yes ☐No

If so, what was his/her/their response: _____

_____

_____

Are you currently pursing any form of compensation, sickness benefit, motor vehicle claim, or any other legal action related to your tinnitus: (check one) ☐Yes ☐No

If so, Medical contact: _____

_____

Legal contact: _____

_____

Initial Tinnitus

When did your tinnitus first begin:_____

Did the tinnitus begin: (check one) ☐Gradually ☐Suddenly

Has the tinnitus been present constantly since this date: (check one) ☐Yes ☐No

If no, when was the break: _____

Were there any accidents/life changes/medication changes/etc. immediately prior to the onset of the tinnitus: (check one)

☐Yes ☐No

If so, which event: (check one) ☐Noise Exposure ☐Head/neck trauma ☐Motor Vehicle Accident

☐Change in hearing ☐Stress ☐Change in health/disease

☐Change in Medication ☐Other:_____

Audiologic History

Are you sensitive to loud noise(s): (check one) ☐Yes ☐No

If so, what noise(s): _____

When did the sensitivity begin: _____

What happened before the sensitivity began: _____

CONTINUED

Do you experience hearing loss: (circle one) Yes No

If so, which ear: (circle one) Right Left Both

If you experience hearing loss, which best describes it (circle one): Gradual Fluctuating Sudden

When did you first notice the hearing loss? _____

What do you think is the cause of the hearing loss? _____

Have you ever had a hearing test: (circle one) Yes No

If so, when: _____

Which ear do you typically use to talk on the telephone: (circle one) Right Left

Please check all of the medical conditions that apply:

☐Ear pain

If checked, which ear: (circle one) Right ear Left ear Both ears

☐Ear drainage

If checked, which ear: (circle one) Right ear Left ear Both ears

Frequency of episodes: _____

Drainage Color: _____ Texture: _____ Odor: _____

☐Dizziness, unsteadiness, vertigo, imbalance

Do you feel dizzy today: (circle one) Yes No

Is the dizziness accompanied by: (circle all that apply)

Hearing Loss Vomiting Nausea Ear Noises/Tinnitus Visual Changes

Does the dizziness feel like: (circle the best choice)

Lightheadedness Fainting/near fainting Imbalance Spinning sensation/Vertigo

When did the dizziness begin: _____

How often does it occur: _____

Have you fallen in the last 12 months: (circle one) Yes No

If yes, have you been injured: (circle one) Yes No If yes, please describe:_____

_____

☐Ear malformations

If checked, which ear: (circle one) Right ear Left ear Both ears

☐History of ear infections

If checked, which ear :(circle one) Right ear Left ear Both ears

☐Previous ear surgery

If checked, which ear: (circle one) Right ear Left ear Both ears

If so, when: _____

☐Sinus/allergy problems

☐History of earwax buildup

If checked, which ear: (circle one) Right ear Left ear Both ears

☐Family history of hearing loss

If checked, who is the family member: _____

CONTINUED

☐Exposure to loud noise: (check one)

If so, when: _____

What type of noise: (check all that apply)

☐Military ☐Recreational ☐Employment ☐Other: _____

Do/Did you wear hearing protection devices: (check one) ☐Always ☐Sometimes ☐Never

☐Developmental disorder/delay. Please explain: _____

☐Other (please describe): _____

_____

Have you ever worn or tried a hearing aid or amplifier: (circle one) Right ear Left ear Both ears

If so, when: _____

What type and/or style of hearing aid or amplifier: _____

Please describe your experience: _____

Do you consider yourself to be a tense/stressed person: (check one) ☐Yes ☐No

What do you do to relax: (check all that apply)

☐Exercise ☐Listen to music ☐Massage

☐Meditation ☐Yoga ☐Other: _____

Do you suffer from headaches/migraines: (check one) ☐Yes ☐No

If so, frequency: _____

Treatment(s): _____

Rank the following in order of your preferred treatment: (1- first, 3- last)

_____Hearing Loss _____Noise Sensitivity _____Tinnitus

Medical History

Current medications, supplements, vitamins- prescription or over-the-counter (OTC):

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

*continue on a separate page, if needed

Do you currently take a Vitamin D supplement: (circle one) Yes No

Allergies (foods, medications, plastics, latex, etc.): _____

_____

Please circle all medical symptoms or conditions that apply:

- Eye problems (such as blurred or double vision, pain): Yes No
- Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues): Yes No
- Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations): Yes No

CONTINUED

- Respiratory issues (such as shortness of breath, cough, wheezing): Yes No
- Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain): Yes No
- Musculoskeletal issues (such as joint pain, swelling, recent trauma): Yes No
- Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness): Yes No
- Psychiatric issues (such as depression, anxiety, compulsions): Yes No
- Endocrine symptoms (such as frequent urination, hot flashes): Yes No
- Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands): Yes No
- Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency): Yes No

Comments related to Review of Symptoms above: _____

_____

Other illnesses, surgeries, injuries, or hospitalizations since birth and their approximate date(s) of occurrence:_____

_____

_____

Have you been immunized: (circle one) Yes No

If yes, for what illnesses/diseases: _____

Have you experienced any of the following major medical conditions (check all that apply):

☐AIDS/HIV	☐Fatigue	☐Malaria
☐Arthritis	☐Genetic Disorders	☐Measles
☐Blood Disorders	☐Headaches	☐Meningitis
☐Cancer	☐Head Injury	☐Mumps
☐Chicken Pox	☐Heart Problems	☐Scarlet Fever
☐Depression	☐High Blood Pressure	☐Stroke
☐Diabetes	☐High Fevers	☐TMJ
☐Diphtheria	☐Influenza	☐Typhoid
☐Encephalitis	☐Malaise	☐Vascular Problems

☐ Other: _____

_____

Do you currently use recreational drugs (circle one): Yes No

If yes, what drugs: _____

How often (circle one): Daily Weekly Monthly Occasionally Rarely

Do you currently use any tobacco products (circle one): Yes No Quit, when: _____

If yes, what do you use (circle one): Cigarettes Cigars Pipe Smokeless Other: _____

If yes, amount of use per day: _____

Do you currently drink alcoholic beverages (circle one): Yes No

If yes, how often (circle one): Daily Weekly Monthly Occasionally Rarely

Anything else? _____

_____

_____

_____

Tinnitus Reaction Questionnaire (TRQ)

Name:_____ Date Completed:_____

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle, general well-being, etc. Some of the effects below may apply to you, some may not. Please answer **all** questions by circling the number that best reflects how your tinnitus has affected you **over the past week.**

	Not at all	A little of the time	Some of the time	A good deal of the time	Almost all of the time
1. My tinnitus has made me unhappy.	0	1	2	3	4
2. My tinnitus has made me feel tense.	0	1	2	3	4
3. My tinnitus has made me feel irritable.	0	1	2	3	4
4. My tinnitus has made me feel angry.	0	1	2	3	4
5. My tinnitus has led me to cry.	0	1	2	3	4
6. My tinnitus has led me to avoid quiet situations.	0	1	2	3	4
7. My tinnitus has made me feel less interested in going out.	0	1	2	3	4
8. My tinnitus has made me feel depressed.	0	1	2	3	4
9. My tinnitus has made me feel annoyed.	0	1	2	3	4
10. My tinnitus has made me feel confused.	0	1	2	3	4
11. My tinnitus has "driven me crazy".	0	1	2	3	4
12. My tinnitus has interfered with my enjoyment of life.	0	1	2	3	4
13. My tinnitus has made it hard for me to concentrate.	0	1	2	3	4
14. My tinnitus has made it hard for me to relax.	0	1	2	3	4
15. My tinnitus has made me feel distressed.	0	1	2	3	4
16. My tinnitus has made me feel helpless.	0	1	2	3	4
17. My tinnitus has made me feel frustrated with things.	0	1	2	3	4
18. My tinnitus has interfered with my ability to work.	0	1	2	3	4
19. My tinnitus has led me to despair.	0	1	2	3	4
20. My tinnitus has led me to avoid noisy situations.	0	1	2	3	4
21. My tinnitus has led me to avoid social situations.	0	1	2	3	4
22. My tinnitus has made me feel hopeless about the future.	0	1	2	3	4
23. My tinnitus has interfered with my sleep.	0	1	2	3	4
24. My tinnitus has led me to think about suicide.	0	1	2	3	4
25. My tinnitus has made me feel panicky.	0	1	2	3	4
26. My tinnitus has made me feel tormented.	0	1	2	3	4
Total					

Wilson et al. 1991

TINNITUS FUNCTIONAL INDEX

Date: _____ 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*

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OVER

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*

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WIDEX®
HIGH DEFINITION HEARING

TINNITUS HANDICAP INVENTORY (THI)

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every question. Please do not skip any questions.

Name:_____ Date:_____

1. Because of your tinnitus, is it difficult for you to concentrate?	☐ Yes	☐ Sometimes	☐ No
2. Does the loudness of your tinnitus make it difficult for you to hear people?	☐ Yes	☐ Sometimes	☐ No
3. Does your tinnitus make you angry?	☐ Yes	☐ Sometimes	☐ No
4. Does your tinnitus make you feel confused?	☐ Yes	☐ Sometimes	☐ No
5. Because of your tinnitus, do you feel desperate?	☐ Yes	☐ Sometimes	☐ No
6. Do you complain a great deal about your tinnitus?	☐ Yes	☐ Sometimes	☐ No
7. Because of your tinnitus, do you have trouble falling asleep at night?	☐ Yes	☐ Sometimes	☐ No
8. Do you feel as though you cannot escape your tinnitus?	☐ Yes	☐ Sometimes	☐ No
9. Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies)?	☐ Yes	☐ Sometimes	☐ No
10. Because of your tinnitus, do you feel frustrated?	☐ Yes	☐ Sometimes	☐ No
11. Because of your tinnitus, do you feel that you have a terrible disease?	☐ Yes	☐ Sometimes	☐ No
12. Does your tinnitus make it difficult for you to enjoy life?	☐ Yes	☐ Sometimes	☐ No
13. Does your tinnitus interfere with your job or household responsibilities?	☐ Yes	☐ Sometimes	☐ No
14. Because of your tinnitus, do you find that you are often irritable?	☐ Yes	☐ Sometimes	☐ No
15. Because of your tinnitus, is it difficult for you to read?	☐ Yes	☐ Sometimes	☐ No
16. Does your tinnitus make you upset?	☐ Yes	☐ Sometimes	☐ No
17. Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and/or friends?	☐ Yes	☐ Sometimes	☐ No
18. Do you find it difficult to focus your attention away from your tinnitus and on other things?	☐ Yes	☐ Sometimes	☐ No
19. Do you feel that you have no control over your tinnitus?	☐ Yes	☐ Sometimes	☐ No
20. Because of your tinnitus, do you often feel tired?	☐ Yes	☐ Sometimes	☐ No
21. Because of your tinnitus, do you feel depressed?	☐ Yes	☐ Sometimes	☐ No
22. Does your tinnitus make you feel anxious?	☐ Yes	☐ Sometimes	☐ No
23. Do you feel that you can no longer cope with your tinnitus?	☐ Yes	☐ Sometimes	☐ No
24. Does your tinnitus get worse when you are under stress?	☐ Yes	☐ Sometimes	☐ No
25. Does your tinnitus make you feel insecure?	☐ Yes	☐ Sometimes	☐ No

For Clinician Use Only

Total Score Per Column ☐ ☐ ☐

Total THI Score: (number of "yes" responses x 4) + (number of "sometimes" responses x 2) = **Total Score** ☐

0 – 16	Slight (Only heard in quiet environments)	GRADE 1
18 – 36	Mild (Easily masked by environmental sounds and easily forgotten with activities)	GRADE 2
38 – 56	Moderate (Noticed in presence of background noise, although daily activities can still be performed)	GRADE 3
58 – 76	Severe (Almost always heard, leads to disturbed sleep patterns and can interfere with daily activities)	GRADE 4
78 – 100	Catastrophic (Always heard, disturbed sleep patterns, difficulty with any activities)	GRADE 5

REFERENCES

Newman, C. W., Jacobson, G. P., & Spitzer, J. B. (1996). Development of the Tinnitus Handicap Inventory. *Arch Otolaryngol Head Neck Surg*, 122, 143-148.

McCombe, A., Bagueley, D., Coles, R., McKenna, L., McKinney, C. & Windle-Taylor, P. (2001). Guidelines for the grading of tinnitus severity: The results of a working group commissioned by the British Association of Otolaryngologists, Head and Neck Surgeons, 1999. *Clin Otolaryngol*, 26, 388-393.

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CFM07/0311

Tinnitus and Hearing Survey

A. Tinnitus

	*No, **not** a problem*	*Yes, a **small** problem*	*Yes, a **moderate** problem*	*Yes, a **big** problem*	*Yes, a **very big** problem*
Over the last week, tinnitus kept me from sleeping.	0	1	2	3	4
Over the last week, tinnitus kept me from concentrating on reading.	0	1	2	3	4
Over the last week, tinnitus kept me from relaxing.	0	1	2	3	4
Over the last week, I couldn't get my mind off of my tinnitus.	0	1	2	3	4
	____	____	____	____	____
		Total of each column			

Grand Total ☐

B. Hearing

Over the last week, I couldn't understand what others were saying in noisy or crowded places.	0	1	2	3	4
Over the last week, I couldn't understand what people were saying on TV or in movies.	0	1	2	3	4
Over the last week, I couldn't understand people with soft voices.	0	1	2	3	4
Over the last week, I couldn't understand what was being said in group conversations.	0	1	2	3	4
	____	____	____	____	____
		Total of each column			

Grand Total ☐

C. Sound Tolerance

Over the last week, sounds were too loud or uncomfortable for me when they seemed normal to others around me.*	0	1	2	3	4

If you responded 1, 2, 3, or 4 to the statement above:

Please list two examples of sounds that are too loud or uncomfortable for you, but seem normal to others:

_____

_____

*If sounds are too loud for you while wearing hearing aids, please tell your audiologist.

For office use only (II): ☐ **M** ☐ **H** ☐ **N**

Iowa Tinnitus Activities Questionnaire (12-item version)

Name: _____Date: _____

Please indicate your agreement with each statement on a scale from 0 (completely disagree) to 100 (completely agree).

#	Statement	0-100
Concentration		
1	I feel like my tinnitus makes it difficult for me to concentrate on some tasks.	
2	I have difficulty focusing my attention on some important tasks because of tinnitus.	
3	My inability to think about something undisturbed is one of the worst effects of my tinnitus.	
Emotion		
4	My emotional peace is one of the worst effects of my tinnitus.	
5	I am depressed because of my tinnitus.	
6	I am anxious because of my tinnitus.	
Hearing		
7	My tinnitus masks some speech sounds.	
8	In addition to my hearing loss, my tinnitus interferes with my understanding of speech.	
9	One of the worst things about my tinnitus is its effect on my speech understanding, over and above any effect of my hearing loss.	
Sleep		
10	I am tired during the day because my tinnitus has disrupted my sleep.	
11	I lie awake at night because of my tinnitus.	
12	When I wake up in the night, my tinnitus makes it difficult to get back to sleep.	

Geriatric Depression Scale (Short Form)
Self-Rated Version

Patient's Name: _____ Date: _____

***Instructions*: Choose the best answer for how you felt over the past week.**

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	YES / NO	
2.	Have you dropped many of your activities and interests?	YES / NO	
3.	Do you feel that your life is empty?	YES / NO	
4.	Do you often get bored?	YES / NO	
5.	Are you in good spirits most of the time?	YES / NO	
6.	Are you afraid that something bad is going to happen to you?	YES / NO	
7.	Do you feel happy most of the time?	YES / NO	
8.	Do you often feel helpless?	YES / NO	
9.	Do you prefer to stay at home, rather than going out and doing new things?	YES / NO	
10.	Do you feel you have more problems with memory than most people?	YES / NO	
11.	Do you think it is wonderful to be alive?	YES / NO	
12.	Do you feel pretty worthless the way you are now?	YES / NO	
13.	Do you feel full of energy?	YES / NO	
14.	Do you feel that your situation is hopeless?	YES / NO	
15.	Do you think that most people are better off than you are?	YES / NO	
		TOTAL	

(Sheikh & Yesavage, 1986)