



HEARING ASSOCIATES

Gabriela Perez-Saenz, Au.D. • Bruce Schachterle, Au.D.

Michael Iliff, Au.D. • John Molina, Au.D.

Doctors of Audiology

PATIENT PROFILE AND CONSENT

Legal Name (First MI Last)		Patient SS#		Patient Date of Birth	
Address		Sex:	Email Address		Marital Status
City, State, Zip		Phone #1/Type of Number		Phone #2/Type of Number	
Employer		Occupation		Please tell us how your heard about our practice	
Referring Physician		Primary Care Physician		Pharmacy	

Insurance Information

<input type="checkbox"/> Card Attached	Primary Insurance	Secondary Insurance
Insurance Name/Subscriber Name		
Subscriber Relationship to Patient		
Subscriber Employer/Ins Policy# and Group#		
Office Visit Copay		

Consent for Treatment: I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the provider has deemed necessary and which are administered to or performed on me under the direction of the provider or his/her designee.

Consent for Treatment of Minors: I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand that I must send a note with the child to the appointment consenting for the child to be treated. The notes must contain the date, a statement of consent, and my signature. Further, I understand that consent for treatment does not alter the legal requirements for confidentiality. I also understand that Colorado Law provides for minors to seek care without parental consent for certain issues.

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Consent to Communicate Medical Results: I, the undersigned, understand that medical results will be communicated directly to me unless I specifically identify individuals to whom information may be communicated (see box below to authorize other family members to receive results). Please indicate how we may inform you of test results (check all that apply):

	Use info previous page	Okay to leave voice mail?	Ok to leave message with another person (see below)
<input type="checkbox"/> Call my work number	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Call my cell phone:	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Call my home number	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Mail to my home address	<input type="checkbox"/>	<input type="checkbox"/> Mail to a different address (at right):	

In the event that I am not available to receive medical results when called upon, I authorize Hearing Consultants of Colorado Springs, LLC. to leave medical information with any of the names identified below. It is my responsibility to notify these persons that such information may be left with them and I agree not to hold Hearing Consultants of Colorado Springs, LLC. responsible for information not conveyed to me through these persons. (Please indicate below which family members are authorized to receive result information.)

Family Information (Please list all other members of your household even if not authorized to receive results.)

Name (First MI Last)	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	Relation	*OK to Release Results? No <input type="checkbox"/> Yes <input type="checkbox"/>
Name (First MI Last)	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	Relation	*OK to Release Results? No <input type="checkbox"/> Yes <input type="checkbox"/>

Emergency Contact Information

Name of relative or friend to contact in case of an emergency		
Name	Relation	Phone

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Please read and initial each of the items below

Initials

_____ I certify to the accuracy of the above information and understand that I am personally responsible for the full amount of my charges regardless of insurance coverage. I authorize the release of any medical or other information necessary to process claims.

_____ I further authorize payment of medical benefits directly to the undersigned provider.

_____ I also hereby acknowledge that I received or have access to Hearing Consultants of Colorado Springs, LLC. Notice of Privacy Practices. This is made available on our website at www.myhearingconsultants.com/patient-forms/, at our office or sent via regular mail.

_____ I understand that if I am unable to make my appointment that I need to call and reschedule 24 hours prior to my appointment. I also understand if I arrive late for my appointment, I may be asked to reschedule, or be worked into the day. If I do not show for my appointment and do not call the office to cancel my appointment in advance, I will be considered a no show and will be charged a \$25 no show fee.

_____ I also understand if my check is returned for non-sufficient funds, I will be responsible for paying a \$25.00 fee in addition to re-issuing payment for the returned check.

Name (please Print)

Signature

Relationship to patient

Date

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TINNITUS QUESTIONNAIRE

NAME: _____ AGE: _____ DATE: ___/___/___

• When did you first experience tinnitus? _____

• How long have you had tinnitus in its present form?
_____ years _____ months

• Briefly describe what you were doing when the tinnitus first became apparent to you.

• Were you experiencing any kind of emotional trauma at the time when you first noticed your tinnitus?

• What do you think is the cause of your tinnitus?

• Where is your tinnitus primarily located?

_____ left ear _____ right ear _____ both ears equally _____ head

other (please explain) _____

• *Using the scale below, indicate the LOUDNESS of:

A) Your tinnitus right now _____ B) Your average tinnitus _____
C) Your tinnitus at its worst _____ D) Your tinnitus at its least _____

0 1 2 3 4 5 6 7 8 9 10
none mild moderate severe excruciating

• Using the scale below, indicate the PITCH of your tinnitus. (It might help to imagine the scale as if it were a piano keyboard.)

0 1 2 3 4 5 6 7 8 9 10
low pitch mid pitch high pitch

• The loudness of your tinnitus is (check one):

- _____ fairly constant from day to day
- _____ fluctuates widely, being very loud some days and very mild other days
- _____ usually constant, but occasionally decreases markedly
- _____ usually constant, but occasionally increases markedly

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• Does your tinnitus appear worse:

_____ when tired	_____ when tense or nervous
_____ at bedtime	_____ after use of alcohol
_____ upon awakening	_____ when relaxed

• Check all items below which describe the sound of your tinnitus:

_____ hissing	_____ ringing	_____ cricket-like	_____ high tension wire
_____ steam whistle	_____ pounding	_____ pulsating	_____ bells
_____ clanging	_____ buzzing	_____ sizzling	_____ clicking
_____ ocean roar	_____ whistle	_____ other _____	

• *To what extent are you bothered or annoyed by your tinnitus?

0	1	2	3	4	5	6	7	8	9	10
not bothered		mild		moderate			severe			extreme

• When are you aware of your tinnitus? _____

• *What percentage of the time are you bothered by your tinnitus? _____

• Is there any time during the day when your tinnitus is most troublesome to you?

_____ at work	_____ in morning
_____ in evening	_____ when trying to concentrate
_____ at social activities	_____ around noise

Other: _____

• Do you consider yourself to be a tense person? _____

• Do you feel that emotional or physical stress worsens the tinnitus? _____.

• *PLEASE TELL US HOW YOUR TINNITUS INTERFERES WITH YOUR ACTIVITIES:

Concentration _____

Work/Chores _____

Family _____

Religious Activities _____

Social/Recreation _____

Exercise _____

Sleep _____

• Does the tinnitus prevent you from falling asleep? _____

• Does the tinnitus awaken you from sleep? _____

• Are you able to fall back asleep, once awakened? _____

Other _____

• Do you have a hearing loss? _____ yes _____ no

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• *Which is more of a problem for you, the hearing difficulty or your tinnitus?
_____ hearing difficulty _____ tinnitus _____ not sure

• Have you been exposed to loud noise? _____ yes _____ no
If so, when: _____ military service _____ work _____ recreation
_____ other _____

• Do you wear ear protection in the presence of loud sounds?
_____ yes _____ no

• Have you ever worn a hearing aid? _____ yes _____ no
If yes, do you currently wear it (them) _____ yes _____ no

• If you are a hearing aid user, how does the aid affect your tinnitus?
_____ makes tinnitus softer _____ makes tinnitus louder _____ no effect

• Are you adversely affected by loud sounds? _____ yes _____ no

Please explain: _____

• How would your life be different if you didn't have tinnitus?

• Have you discussed your tinnitus with friends or family members? _____

What was their reaction? _____

• Are there other members of your family, or friends who suffer from tinnitus? _____

• Do you live alone? _____

TREATMENT HISTORY:

• Please list all evaluations and/or treatments (including psychiatric or psychologic) you have had for your tinnitus. Please include the names of the specialists who have performed evaluations or treatments, and the approximate dates on which they were performed, using the reverse side, if necessary.

Provider	What was done	Date	Result
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

• Please list any surgeries you have had (potentially related to your current symptom of tinnitus)

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• Please list the medications you are currently taking for tinnitus.

Medication	Dose	How often?	Does it help? Yes ___ No ___	Doctor
_____	_____	_____	Yes ___ No ___	_____
_____	_____	_____	Yes ___ No ___	_____
_____	_____	_____	Yes ___ No ___	_____
_____	_____	_____	Yes ___ No ___	_____

• What other medications have you tried in the past for tinnitus relief?

Medication	Dose	How often?	Does it help? Yes ___ No ___	Stopped (Why?)
_____	_____	_____	Yes ___ No ___	_____
_____	_____	_____	Yes ___ No ___	_____
_____	_____	_____	Yes ___ No ___	_____
_____	_____	_____	Yes ___ No ___	_____

• Please list all other medications you currently take:

Medication	Dose	How often?	Purpose?	Doctor
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

• Using the number codes below, please indicate the results of those treatments you have tried for your tinnitus. If you have not tried a given treatment, please place an "NA" in the blank for that treatment.

1 = Major relief 2 = Some relief 3 = No relief 4 = Some relief with bad side effects 5 = Tinnitus worse
NA = Not applicable, treatment not tried

- | | |
|----------------------|--|
| ___ Surgery | ___ Acupuncture |
| ___ Drug Therapy | ___ Massage |
| ___ Hearing aids | ___ Homeopathy |
| ___ Masking therapy | ___ Biofeedback |
| ___ Physical therapy | ___ Chiropractic |
| ___ Antidepressants | ___ Relaxation training or hypnosis |
| ___ Exercise program | ___ Psychotherapy or other counseling |
| ___ Dental | ___ Dietary Management or nutrition counseling |
| ___ Other | _____ |

- Are you employed? _____ # of hours/week _____
- What is your occupation? _____
- Are you satisfied? _____
- If not employed, is your unemployment due to tinnitus? _____

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• CHECKLIST OF PROBLEMS (Please check all items you feel are applicable to you):

- poor health for much of your life
- history of middle ear disease
- history of Meniere's disease
- history of otosclerosis
- history of facial pain/numbness or paralysis
- history of labyrinthitis
- history of mastoiditis
- history of ear surgery
- history of ear surgery
- migraine headaches
- hyperventilation syndrome
- hypertension (high blood pressure)
- cancer
- dizziness/imbalance or vertigo
- arthritis
- heart disease
- depression
- increased use of alcohol or drugs
- fair to poor dietary habits
- moderate to excessive use of caffeine substances (cola, coffee, chocolate)
- low back pain
- whiplash or neck injury
- tinnitus is altered by change in position
- stiffness or reduced mobility of the neck
- limitations and/or pain when moving head
- significant headaches
- headaches that change with head movement
- tenderness/pain in the jaw area with or without chewing
- clenching or grinding of teeth
- limitation and/or pain with mouth opening or movement side to side
- history of clicking/locking/popping of the jaw
- personal or family history of diabetes/alcoholism/hypoglycemia (circle)
- personal or family history of hyperthyroid, hypothyroid or auto immune disease
- personal or family history of any type of hyperlipidemia
- personal or family history of inhalant or food allergies
- history of Epstein Barr-virus, cytomegalovirus or hepatitis (circle)
- history of excessive X-ray exposure around the head and neck
- poor thyroid or parathyroid function
- Lyme Disease

• DO YOU HAVE LEGAL ACTION PENDING IN RELATION TO YOUR TINNITUS?

yes no

• IF NOT, ARE YOU PLANNING LEGAL ACTION?

yes no

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• WHAT IS THE NATURE OF THIS LEGAL ACTION?

personal injury workers comp liability

Please explain _____

• IF YOU HAVE RETAINED AN ATTORNEY IN RELATION TO YOUR TINNITUS, PLEASE LIST:

Attorney's name: _____

Phone #: _____ Address _____

City _____ State _____ Zip _____

I, authorize the release of all information in my Hearing Consultants of Colorado Springs, LLC. Audiology Chart to the following individuals:

Name: _____

Address: _____ Date: _____

Signature: _____ Date: _____

Name: _____

Address: _____ Date: _____

Signature: _____ Date: _____

Name: _____

Address: _____ Date: _____

Signature: _____ Date: _____

Used with permission by Robert Sweetow, Ph.D.

UCSF

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TINNITUS HANDICAP INVENTORY

Name: _____ Date: _____

The purpose of the scale is to identify the problems your tinnitus may be causing you.
Circle “**Yes**”, “**Sometimes**”, or “**No**” for each question. Do not skip a question.

1. Because of you 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 to sleep 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 social activities? (Such as dinner or 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**

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TINNITUS HANDICAP INVENTORY

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 relationship with members of your family and 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**

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