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

❑ 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)
❑ Call my work number	❑	❑ Yes ❑ No	❑ Yes ❑ No
❑ Call my cell phone:	❑	❑ Yes ❑ No	❑ Yes ❑ No
❑ Call my home number	❑	❑ Yes ❑ No	❑ Yes ❑ No
❑ Mail to my home address	❑	❑ 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 Associates, 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 Associates, 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 ❑	Female ❑	Date of Birth	Relation	*OK to Release Results? No ❑ Yes ❑
Name (First MI Last)	Male ❑	Female ❑	Date of Birth	Relation	*OK to Release Results? No ❑ Yes ❑

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 herby acknowledge that I received or have access to Hearing Associates, 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______________________________
ReligiousActivities______________________________
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?	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?	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
____Drug Therapy
____Hearing aids
____Masking therapy
____Physical therapy
____Antidepressants
____Exercise program
____Dental
____Other____

_____Acupuncture
_____Massage
_____Homeopathy
_____Biofeedback
_____Chiropractic
_____Relaxation training or hypnosis
_____Psychotherapy or other counseling
_____Dietary Management or nutrition counseling

• 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 labrynthitis
______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
______clinching 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 Associates, LLC Audiology Chart to the following individuals:

Name: ______________________________

Address: ______________________________Date: __________

Signature: ______________________________Date: __________

Name: ______________________________

Address: ______________________________Date: __________

Signature: ______________________________Date: __________

Name: ______________________________

Address: ______________________________Date: __________

Signature: ______________________________Date: __________

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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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