HEARING ASSOCIATES
Gabriela Perez-Saenz, Au.D.
Michael Iliff, Au.D. • John Molina, Au.D.
Doctors of Audiology

Patient Profile and Consent:

Legal Name: _____

Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F Marital Status: _____
mm dd year

Mailing Address: _____
Street City State Zip

Primary Phone: _____

Can we leave a message? ☐ Yes ☐ No

Secondary Phone: _____

Can we leave a message? ☐ Yes ☐ No

Email address: _____

Primary Insurance Information:

Primary Insurance: _____

Subscriber Name: _____

Subscriber Relationship: _____

Subscriber DOB: _____/_____/_____
mm dd year

Policy number: _____

Group number: _____

How did you hear about us? Please check all that apply.

☐ Sponsored event ☐ TV Commercial

☐ Social Media ☐ Website

☐ Insurance provider ☐ Employer

☐ KOAA Healthy Family ☐ Physician

☐ Google/Internet search ☐ Direct mail

☐ Friend/current patient referral

Who can we thank for the referral?

_____

_____

Occupation: _____

Current Employer: _____

Primary Care Physician: _____

Referring Physician: _____

Patient SSN: _____

Secondary Insurance Information:

Secondary Insurance: _____

Subscriber Name: _____

Subscriber Relationship: _____

Subscriber DOB: _____/_____/_____
mm dd year

Policy number: _____

Group number: _____

Family Contact Information:

Name: _____
First MI Last

Relation: _____ DOB: _____/_____/_____
mm dd year

Phone number: _____

Can we leave results? ☐ Yes ☐ No

May we leave a message? ☐ Yes ☐ No

May we contact the person listed above in case of an emergency? ☐ Yes ☐ No

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Please read and acknowledge by signing below:

- I certify to the accuracy of the above information.
- I understand that I am personally responsible for the amount of charges regardless of insurance coverage and authorize the release of any medical or other information necessary to process claims.
- I understand my insurance benefit will be checked as a courtesy, however, I am responsible for understanding my insurance coverage.
- I further authorize payment of medical benefits directly to the undersigned provider.
- I hereby acknowledge that I received or have access to Hearing Associates' Notice of Privacy Practices. This is made available on our website, at our office, or can be sent via email.
- I understand that if I am unable to make my appointment, 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 to the office to cancel my appointment in advance, I will be considered as a no-show and will be charged a $25 no-show fee.**
- I understand if my check is returned for non-sufficient funds, I will be responsible for paying a $25 fee in addition to re-issuing payment for a returned check.
- **Consent for Treatment:** I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the provider deems necessary and which are administered to or performed on me under the direction of the provider or his/her designee.
- **Consent of 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 I must send a note with the child to the appointment for consenting treatment. 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.

_____ _____

Print Name Signature

_____ _____

Relationship to Patient Date

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Audiologic Case History:

Patient Name: _____ **Date of birth:**_____

Chief Complaint: _____

Do you experience hearing loss?
☐ Yes ☐ No

Hearing loss is in the:
☐ Right ear ☐ Left ear ☐ Both ears

Onset has been:
☐ Progressive ☐ Sudden ☐ Fluctuating

How long have you had hearing loss?
_____Years _____Months _____Days

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

Noise exposure in your lifetime (please check all that apply):
☐ Military ☐ Musician ☐ Race cars
☐ Concerts ☐ Firearms ☐ Construction
☐ Power tools ☐ Heavy equipment

Other:_____

Do you wear hearing protection in the presence of loud sounds?
☐ Yes ☐ No

If you have a hearing loss, which is more of a problem for you?
☐ Hearing loss ☐ Tinnitus ☐ Not sure

Otologic history:
☐ Ear surgery
☐ Dizziness
☐ Ear infections
☐ Family history of hearing loss
☐ Ear pain/drainage
☐ Wax build-up

Situations in which you have difficulty hearing:
☐ In the car
☐ Meetings
☐ Watching TV
☐ One-on-one conversations
☐ Place of worship
☐ On the phone
☐ Restaurants

Other: _____

Does your hearing loss cause:
☐ You to be embarrassed
☐ Arguments with your family
☐ You to become frustrated
☐ You to withdraw from social engagements
☐ You to feel handicapped by your hearing loss

Other: _____

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Comprehensive Case History:

Patient Name: _____ **Date of birth:**_____

Chief Complaint: _____

Do you use tobacco products?

☐ Yes ☐ No

If yes, do you smoke:

☐ Cigarettes ☐ Cigars ☐ Pipe

☐ Smokeless Other: _____

If yes, how many do you smoke daily?

Frequency per day: _____

Do you consume alcohol?

☐ Yes ☐ No

If yes, how often?

☐ Daily ☐ Weekly ☐ Monthly

☐ Rarely ☐ Occasionally

Please check all medical conditions that apply:

☐ History of Cancer ☐ Genetic disorder

☐ Chemotherapy ☐ Headaches

☐ Meningitis ☐ High fever

☐ Diabetes ☐ Heart problems

☐ Encephalitis ☐ High blood pressure

☐ Radiation ☐ Autoimmune disease

☐ Stroke ☐ Vascular problems

☐ Dizziness

Other conditions: _____

If yes to dizziness, please describe the type:

_____

Eye problems:

☐ Vision loss ☐ Blurred vision

☐ Glasses

ENT problems:

☐ TMJ ☐ Dental issues

☐ Nose bleeds ☐ Trouble swallowing

Cardiovascular:

☐ Pacemaker ☐ Hypertension

Musculoskeletal symptoms:

☐ Arthritis ☐ Joint pain

Respiratory:

☐ Coughing ☐ Wheezing

☐ Asthma ☐ Shortness of breath

Neurological symptoms:

☐ Numbness ☐ Muscle weakness

☐ Seizures ☐ Migraines

Psychiatric issues:

☐ Anxiety ☐ Compulsions

☐ Depression

Other conditions: _____

Allergies:

_____

_____

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Tinnitus Questionnaire

Patient Name: _____ **Date of birth:_____**

Chief Complaint: _____

- 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:

  Your tinnitus right now _____ Your average tinnitus_____

  Your tinnitus at it's worst_____ Your tinnitus at it's 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 form 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 _____when trying to concentrate
  _____in evening _____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/Recreational Activities_____
- 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: _____
- 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? _____

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Treatment History

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

Provider	What was done	Date	Result

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

_____

_____

- Please list any medications you are currently taking for tinnitus:

Medication	Dose	How often?	Does it help?	Prescribing Doctor

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

Medication	Dose	How often?	Does it help?	Stopped? Why?

- Please list all other medication you currently take:

Medication	Dose	How often?	Purpose?	Prescribing Doctor

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- 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 worsened *NA = Not applicable, treatment not tried*

_____Surgery	_____Acupuncture	_____Drug therapy	_____Massage
_____Hearing aids	_____Homeopathy	_____Masking therapy	_____Biofeedback
_____Physical therapy	_____Chiropractic	_____Antidepressants	_____Dental
_____Exercise program		_____Dietary management or nutrition counseling	
_____Relaxation training or hypnosis		_____Psychotherapy or other counseling	

_____Other: _____

- Are you employed? _____ Number of hours per week: _____
- What is your occupation? _____
- Are you satisfied?_____
- If not employed, is your unemployment due to the tinnitus? _____
- 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
  - _____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 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

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

  _____YES _____NO
- IF NOT, ARE YOU PLANNING LEGAL ACTION?

  _____YES _____NO
- 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 Hearing Associates, LLC. Audiology Chart to the following individuals:

  Name: _____

  Address: _____

  Signature: _____ Date: _____

  Name: _____

  Address: _____

  Signature: _____ Date: _____

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Tinnitus Handicap Inventory

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 hearpeople?
   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**
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 otherthings?
    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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