Tinnitus Intake Form

NAME: _____ AGE: _____ DATE: ___/____/____
REFERRED BY: _____ DAYTIME PHONE: _____
HOME PHONE: _____

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 when you first noticed your tinnitus? ☐ Yes ☐ No Describe:_____

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: _____

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

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 _____whistle
_____steam whistle _____pounding _____pulsating _____bells
_____clanging _____buzzing _____sizzling _____clicking
_____ocean roar _____high tension wire _____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 aware of 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? ☐ Yes ☐ No Comments:_____

Do you feel that emotional or physical stress worsens the tinnitus? ☐ Yes ☐ No 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? ☐ Yes ☐ No
Describe:_____
Does the tinnitus awaken you from sleep? ☐ Yes ☐ No
Describe: _____
Are you able to fall back asleep, once awakened? ☐ Yes ☐ No
Describe: _____
Other: _____

Do you have a hearing loss? ☐ Yes ☐ No

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
Describe: _____

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

Have you discussed your tinnitus with friends or family members? ☐ Yes ☐ No
What was their reaction? _____

Are there other members of your family, or friends who suffer from tinnitus? ☐ Yes ☐ No Whom:_____

Do you live alone? ☐ Yes ☐ No

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	Treatment	Date	Results

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

_____
_____
_____

Please list the medications you are **currently** taking for tinnitus:

Medication	Dose	Frequency	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	Frequency	Did it help	Stopped (why?)
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Please list all other medications you currently take:

Medication	Dose	Frequency	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? ☐ Yes ☐ No Number of hours per week:_____
What is your occupation? _____
Are you satisfied? ☐ Yes ☐ No Comments: _____
If not employed, is your unemployment due to tinnitus? ☐ Yes ☐ No

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
_____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
_____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

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_____

*Reference: UCSF Audiology