# **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 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

- 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 | ☐ Ticking |
| ☐ 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 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
- 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? ☐ Yes ☐ No

  What was their reaction?

_____

_____

- Are there other members of your family or friends who suffer from tinnitus? ☐ Yes ☐ No
- 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 | 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):

_____

_____

_____

- 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 | _____ 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?_____ No. of hours per week _____
- What is your occupation?_____
- Are you satisfied?_____
- If not employed, is your unemployment due to tinnitus?_____



 

- Do you have any ear, nose or throat diseases?

- Do you have any other diseases that affect you in your daily life?

- Any other issues you would like us to know about?