TINNITUS INTAKE FORM

Hudson Valley AUDIOLOGY CENTER

Name: _____ Date: _____

1. Have you attended one of our **Tinnitus Seminars**?

   Yes No

2. **How long** have you been aware of your tinnitus?

   Less than 1 year 1-3 years 4-10 years 10+ years

3. **How** did the tinnitus initially **appear**?

   Suddenly More Gradually Unsure

4. Did any illness, accident, or other special circumstances associate with **the onset** of your tinnitus?

   Yes; _____ No

5. Which best describes the **duration of time** you are aware of your tinnitus?

   Few minutes Several Hours Several Days Constant

6. **How much** of a problem is your tinnitus?

   Not a problem Mild problem Moderate problem Severe problem

7. **Where** does your tinnitus appear to be **located**?

   Left Ear Right Ear Both Ears In my Head

8. Is your tinnitus **worse** in a certain **location**?

   No, both ears equal Yes, left ear Yes, right ear Other

9. Please **circle** the sound and/or sounds that **most closely resemble** your tinnitus.

Ringing	Clear tone	Multiple tones	Whistling
Hissing	Buzzing	Humming	Music
Sizzling	Crickets	Pulsating	Pounding
Roaring	Clicking	Static	Other_____

10. Please **circle** the number that best describes **the loudness** of your usual tinnitus:

    Very Quiet — Intermediate — Very Loud

    1 2 3 4 5 6 7 8 9 10

11. Has the loudness of your **tinnitus fluctuated**?

    Never/Rarely Monthly/Sometimes Weekly/Commonly Always/Daily

12. Has anything else **caused changes** in your tinnitus (e.g. noise exposure, stress/fatigue, alcohol, tobacco, medication, etc.)?

Tinnitus and Hearing Survey

	*No, **not** a problem*	*Yes, a **small** problem*	*Yes, a **moderate** problem*	*Yes, a **big** problem*	*Yes, a **very big** problem*	
A. Tinnitus						
Over the last week, tinnitus kept me from sleeping.	0	1	2	3	4	
Over the last week, tinnitus kept me from concentrating on reading.	0	1	2	3	4	
Over the last week, tinnitus kept me from relaxing.	0	1	2	3	4	Grand Total
Over the last week, I couldn't get my mind off of my tinnitus.	0	1	2	3	4	☐
	___	___	___	___	___	
			Total of each column			
B. Hearing						
Over the last week, I couldn't understand what others were saying in noisy or crowded places.	0	1	2	3	4	
Over the last week, I couldn't understand what people were saying on TV or in movies.	0	1	2	3	4	
Over the last week, I couldn't understand people with soft voices.	0	1	2	3	4	Grand Total
Over the last week, I couldn't understand what was being said in group conversations.	0	1	2	3	4	☐
	___	___	___	___	___	
			Total of each column			
C. Sound Tolerance						
Over the last week, everyday sounds were too loud for me.*	0	1	2	3	4	
If you responded 1, 2, 3 or 4 to the statement above:						
Being in a meeting with 5 to 10 people would be too loud for me.*	0	1	2	3	4	

*If sounds are too loud for you when wearing hearing aids, please tell your audiologist

TINNITUS HANDICAP INVENTORY

Hudson Valley AUDIOLOGY CENTER

Instructions: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every question.

ITEM	QUESTION	Yes	No	Sometimes
1	Because of your tinnitus, is it difficult for you to **concentrate**?			
2	Does the loudness of your tinnitus make it difficult for you to **hear** people?			
3	Does your tinnitus make you **angry**?			
4	Does your tinnitus make you **confused**?			
5	Because of your tinnitus, are you **desperate**?			
6	Do you **complain** a great deal about your tinnitus?			
7	Because of you tinnitus, do you have **trouble falling asleep** at night?			
8	Do you feel as though you **cannot escape** from your tinnitus?			
9	Does your tinnitus **interfere** with your ability to enjoy **social activities** (such as going out to dinner or to the theatre)?			
10	Because of your tinnitus, do you feel **frustrated**?			
11	Because of your tinnitus, do you feel that you have a terrible **disease**?			
12	Does your tinnitus make it difficult for you to **enjoy life**?			
13	Does your tinnitus **interfere** with your **job or household responsibilities**?			
14	Because of your tinnitus, do you find that you are **often irritable**?			
15	Because of your tinnitus, is it **difficult** for you to **read**?			
16	Does your tinnitus make you **upset**?			
17	Do you feel that your tinnitus has placed **stress on your relationships** with family members and/or friends?			
18	Do you find it difficult to **focus your attention away** from your tinnitus and on to other things?			
19	Do you feel that you have **no control over** your tinnitus?			
20	Because of your tinnitus, do you often feel **tired**?			
21	Because of your tinnitus, do you feel **depressed**?			
22	Does your tinnitus make you feel **anxious**?			
23	Do you feel you can **no longer cope** with your tinnitus?			
24	Does your tinnitus get **worse** when you are **under stress**?			
25	Does your tinnitus make you **feel insecure**?			
		x 4	**x 0**	**x 2**
	=			
	TOTAL			

Classification (for Audiologist use only):

- 0-16; slight or no handicap
- 18-36; mild handicap
- 38-56; moderate handicap
- 58-76; severe handicap
- 78-100; catastrophic handicap

Notes: