Cochlear Implant Evaluation Intake

Hudson Valley AUDIOLOGY CENTER

Name_____ Date _____/_____/_____

Statement of Problem

At what age was your hearing loss identified? _____

What was the cause of your hearing loss? _____

Is there a family history of hearing loss? If yes, please describe. _____

_____

Do you hear better out of one ear? YES NO If yes, which ear? _____

Amplification History Do you wear hearing aids? RIGHT EAR LEFT EAR BOTH N/A

If yes, when did you start wearing hearing aids? RIGHT: _____ LEFT: _____

How many hours per day do you wear your hearing aid(s)? _____

How old are your current hearing aids? _____

Do you use any assistive listening devices (Caption phone, TTY, FM system, closed captioning)?

_____

Preferred communication method(s): ORAL SIGN LANGUAGE TOTAL COMMUNICATION

Health History *Please circle if you have any of the following:*

Tinnitus Epilepsy Seizures Stroke Hypertension (high blood pressure)

Diabetes Cancer Allergies Dizziness Dementia Depression/Anxiety

Other: _____

History of ear infections? _____

History of ear surgery? _____

Has your vision been evaluated? YES NO If yes, when? _____

Current Medications: _____

_____

Hearing Handicap Inventory for Adults

Hudson Valley AUDIOLOGY CENTER

Name: _____

Date: _____

Instructions: The purpose of the scale is to identify the problems your hearing loss may be causing you each question.

Check: Yes, Sometimes, or No
Do not skip a question if you avoid a situation because of a hearing problem.

		Yes (4)	Sometimes (2)	No (0)
S1	Does a hearing problem cause you to use the phone less often than you would like?			
E2	Does a hearing problem cause you to feel embarrassed when meeting new people?			
S3	Does a hearing problem cause you to avoid groups of people?			
E-4	Does a hearing problem make you irritable?			
E-5	Does a hearing problem cause you to feel frustrated when talking to members of your family?			
S-6	Does a hearing problem cause you difficulty when attending a party?			
S-7	Does a hearing problem cause you difficulty hearing/understanding coworkers, clients, or customers?			
E-8	Do you feel handicapped by a hearing problem?			
S-9	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?			
E-1 0	Does a hearing problem cause you to feel frustrated when talking to coworkers,			

S-1 1	Does a hearing problem cause you difficulty in the movies of theater?			
E-12	Does a hearing problem cause you to be nervous?			
S-13	Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?			
E-14	Does a hearing problem cause you to have arguments with family members?			
S-15	Does a hearing problem cause you difficulty when listening to TV or radio?			
S-16	Does a hearing problem cause you to go shopping less often than you would like?			
E-17	Does any problem or difficulty with your hearing upset you at all?			
E-18	Does a hearing problem cause you to want to be by yourself?			
S-19	Does a hearing problem cause you to talk to family members less often than you would like?			
E-20	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
S-21	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			
E-22	Does a hearing problem cause you to feel depressed?			
S-23	Does a hearing problem cause you to listen to TV or radio less often than you would like?			
E-24	Does a hearing problem cause you to feel uncomfortable when talking to friends?			
E-25	Does a hearing problem cause you to feel left out when you are with a group of people?			

Total # points	/100	Total # of points for SOCIAL	/48	Total # of points for EMOTIONAL	/52

☐ 0-16% = No handicap
☐ 18-42% = Mild-Moderate Handicap
☐ 44%+ = Significant Handicap

Adapted from Newman, C.W., Weinstein, B.E., Jacobson, G.P. and Hug, G.A., Test-retest reliability of the Hearing Handicap Inventory for Adults, Ear Hear., 12, 355-357 (1991)

Cochlear Implant Quality of Life-10 Global

INSTRUCTIONS: Think about your daily life with your cochlear implant (and/or hearing aid, if you also use one). Answer how often each of the following statements applies to your feelings and experiences. Answer how often each statement applies even if you don't use cochlear implants or hearing aids.

	Never	Rarely	Sometimes	Often	Always
1. I am able to have a conversation in a quiet place without asking the other person to repeat themselves					
2. I can hear and understand without looking at the person speaking					
3. I can understand strangers without lip-reading in a noisy place					
4. I feel comfortable being myself					
5. I keep quiet in a conversation to avoid saying the wrong thing					
6. I am able to enjoy listening to the radio and TV					
7. I can hear someone approaching from behind					
8. I am able to follow a conversation with minimal effort					
9. I have to concentrate when having a conversation with strangers when in a noisy place					
10. I avoid socializing with friends, relatives, or neighbors due to my hearing loss					

TINNITUS HANDICAP INVENTORY

Patient Name: _____ Date: _____

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every question. Please do not skip any questions.

1. Because of your 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 your social activities (such as going out to dinner, to the 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 relationships 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

FOR CLINICIAN USE ONLY

Total Per Column			
	x4	x2	x0
Total Score	+	+	=

Newman, C.W., Jacobson, G.P., Spitzer, J.B. (1996). Development of the Tinnitus Handicap Inventory. Arch Otolaryngol Head Neck Surg, 122, 143-8.

To interpret the score please refer to the Tinnitus Handicap Severity Scale shown on the reverse side.

TINNITUS HANDICAP INVENTORY SEVERITY SCALE

GRADE	SCORE	DESCRIPTION
1	0-16	Slight: Only heard in quiet environment, very easily masked. No interference with sleep or daily activities.
2	18-36	Mild: Easily masked by environmental sounds and easily forgotten with activities. May occasionally interfere with sleep but not daily activities.
3	38-56	Moderate: May be noticed, even in the presence of background or environmental noise, although daily activities may still be performed.
4	58-76	Severe: Almost always heard, rarely, if ever, masked. Leads to disturbed sleep pattern and can interfere with ability to carry out normal daily activities. Quiet activities affected adversely.
5	78-100	Catastrophic: Always heard, disturbed sleep patterns, difficulty with any activity.

McCombe, A., Baguely, D., Coles, R., McKenna, L., McKinney, C. & Windle-Taylor, P. (2001). Guidelines for the grading of tinnitus severity: the results a working group commissioned by the British Association of Otolaryngologists, Head and Neck Surgeons, 999. Clin. Otolarynogol 26, 388-393.

NAME: **DATE**:

Vanderbilt Fatigue Scale- Adult version-10 items (VFS-A-10)

Sometimes communicating with others, or just listening, can be physically, mentally, or emotionally tiring. **For each item below, select the SINGLE response that best describes how often you experience the following in a typical WEEK.**

		Never/ Almost Never	Rarely	Sometimes	Often	Almost Always/ Always
1.	I feel worn out from everyday listening.	0	1	2	3	4
2.	Struggling to listen and understand makes me feel tired.	0	1	2	3	4
3.	I get so exhausted from listening that I cannot do the things I enjoy.	0	1	2	3	4
4.	I schedule my day to avoid getting tired from listening.	0	1	2	3	4
5.	I get so tired from listening that I start to miss details in a conversation.	0	1	2	3	4
6.	I get so exhausted from listening that I go to bed early.	0	1	2	3	4
7.	I withdraw when I am unable to follow conversations in noisy places.	0	1	2	3	4
8.	Feeling tired from listening causes strain on my relationships.	0	1	2	3	4
9.	I feel emotionally drained when it is hard for me to listen and understand.	0	1	2	3	4
10.	It takes a lot of energy to listen and understand.	0	1	2	3	4

Summed Scoring

To calculate a score simply sum the responses for each item. Scores can range from a minimum of 0 to a maximum of 40.

Item Response Theory (IRT) Scoring

We are currently developing R code to allow for IRT scoring of data sets. Once completed the code will be available for free download.

SSQ12 Instructions

The following questions inquire about aspects of your ability and experience hearing and listening in different situations.

For each question, put a mark, such as a cross (x), **anywhere** on the scale shown against each question that runs from 0 through to 10. Putting a mark at **10** means that you would be **perfectly** able to do or experience what is described in the question. Putting a mark at **0** means you would be quite **unable** to do or experience what is described.

As an example, question 1 asks about having a conversation with someone while the TV is on at the same time. If you are well able to do this then put a mark up toward the right-hand end of the scale. If you could follow about half the conversation in this situation put the mark around the mid-point, and so on.

We expect that all the questions are relevant to your everyday experience, but if a question describes a situation that does not apply to you, put a cross in the "not applicable" box. Please also write a note next to that question explaining why it does not apply in your case

Your name:	**Today's date**	**Your age**

Please check one of these options:

I have **no** hearing aid/s ☐

I use **one** hearing aid (**left ear**) ☐

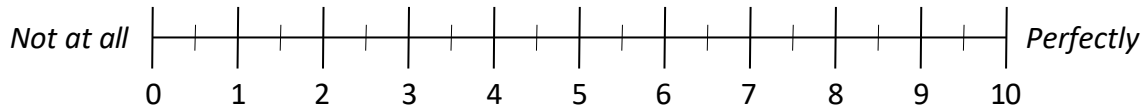
I use **one** hearing aid (**right ear**) ☐

I use **two** hearing aids (**both ears**) ☐

If you have been using hearing aid/s, for how long?

Left ear	***Right ear***
_____ years	_____ years
_____ months	_____ months
or _____ weeks	or _____ weeks

1. You are talking with one other person and there is a TV on in the same room. Without turning the TV down, can you follow what the person you're talking to says?



Not applicable ☐

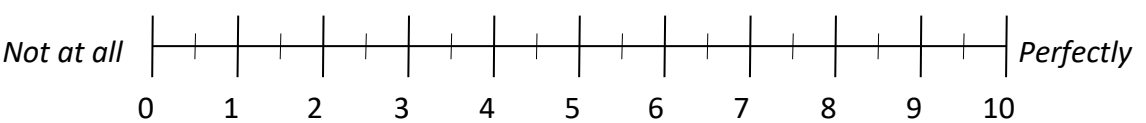
2. You are listening to someone talking to you, while at the same time trying to follow the news on TV. Can you follow what both people are saying?

Not applicable ☐

3. You are in conversation with one person in a room where there are many other people talking. Can you follow what the person you are talking to is saying?

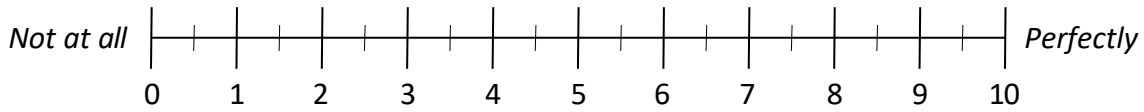
Not applicable ☐

4. You are in a group of about five people in a busy restaurant. You can see everyone else in the group. Can you follow the conversation?



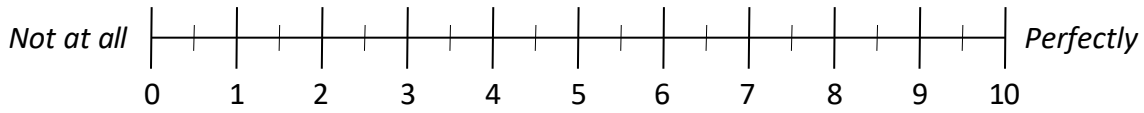
Not applicable ☐

5. You are with a group and the conversation switches from one person to another. Can you easily follow the conversation without missing the start of what each new speaker is saying?



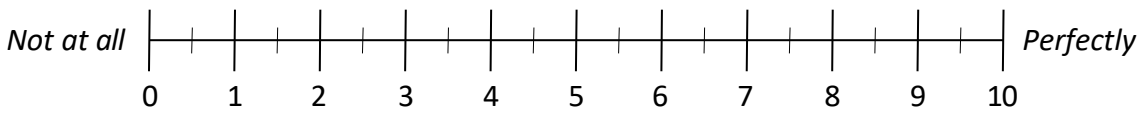
Not applicable ☐

6. You are outside. A dog barks loudly. Can you tell immediately where it is, without having to look?



Not applicable ☐

7. Can you tell how far away a bus or a truck is, from the sound?

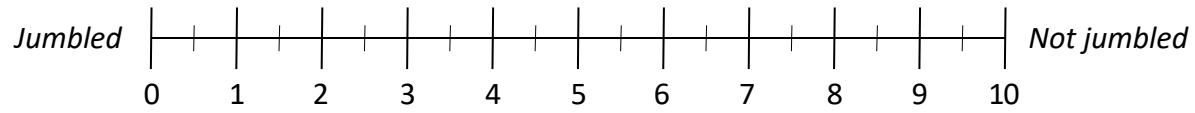


Not applicable ☐

8. Can you tell from the sound whether a bus or truck is coming towards you or going away?

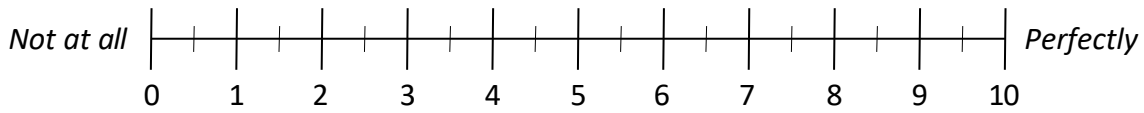
Not applicable ☐

9. When you hear more than one sound at a time, do you have the impression that it seems like a single jumbled sound?



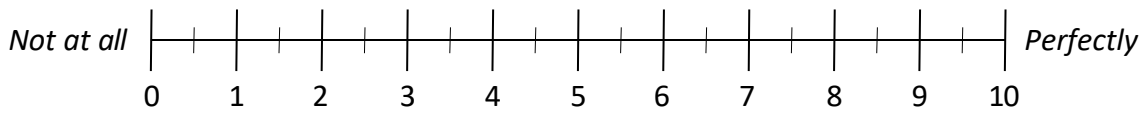
Not applicable ☐

10. When you listen to music, can you make out which instruments are playing?



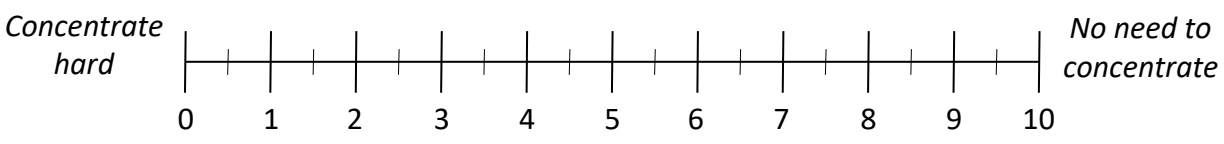
Not applicable ☐

11. Do everyday sounds that you can hear easily seem clear to you (not blurred)?



Not applicable ☐

12. Do you have to concentrate very much when listening to someone or something?



Not applicable ☐