ELEVATE AUDIOLOGY
Hearing & Tinnitus Center

Tinnitus Case History

DEMOGRAPHICS

Name: _____ Today's Date: _____

Birthdate: _____ Age: _____

Referring/Primary Care Physician(s): _____

Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced ___ Other
___ Mr. ___ Mrs. ___ Ms. ___ Miss ___ Dr.

What is your primary reason for coming in today?_____

Who can we thank for sending you to our office today? _____

HEARING HISTORY

Have you ever had a hearing evaluation before? ___ Yes ___ No
If you suspect a hearing loss, do you feel the onset was: ___ Gradual ___ Sudden ___ Fluctuating
Have you been exposed to very loud sounds? ___ Yes ___ No
If yes, _____Military _____Recreational ___ Employment ___ Music
Have you ever worn a hearing aid? ___ Yes ___ No
Do you use a hearing aid now? ___ Yes ___ No
Check if you have trouble hearing any of the following:

___ Doorbell ___ Telephone Ring ___ Alarm Clock ___ Smoke Alarm

MEDICAL HISTORY

Have you had earaches or drainage from your ears in the past 90 days? ___ Yes ___ No
Have you ever had medical or surgical treatment for your ears? ___ Yes ___ No
Do you ever experience balance issues, dizziness, lightheadedness, or falls? ___ Yes ___ No
Have you ever had a significant head injury? ___ Yes ___ No
Do you have a known *genetic* family history of hearing loss or ear problems? ___ Yes ___ No
Are you taking blood thinners? ___ Yes ___ No
Do you smoke anything or exposed to secondhand smoke? ___ Smoker ___ No ___ SH
Do you or your family have concerns about your memory or brain health? ___ Yes ___ No
Have you ever been diagnosed with any of the following?

□ Anxiety	□ Autoimmune Disorder	□ Bell's Palsy	Blood Pressure □ High □ Low	□ Cancer □ Chemo □ Radiation	□ Chronic Kidney Disease	□ Concussion/ Skull Fracture	□ Dementia or Alzheimer's
□ Depression	Diabetes □ Type I □ Type II	□ Heart Disease	□ Hepatitis	□ High Fevers	□ HIV/AIDS	□ Latex, acrylic, or silicone allergy	□ Measles
□ Meningitis	□ Mild Cognitive Impairment	□ Multiple Sclerosis	□ Mumps	□ Neurological Disorders	□ Pacemaker	□ Parkinson's	□ Scarlet Fever
□ Seizures	□ Sinus and/or allergy issues	□ Stroke/TIA	□ Thyroid Issues	□ Tuberculosis	□ Vision Issues		
□ Other, please explain: _____							

Is there any other important information related to your hearing that the doctor should know?

_____**Wh**

at do you consider is your main problem? ☐ **Hearing** ☐ **Tinnitus** ☐ **Sound tolerance**

TINNITUS

Tinnitus refers to any kind of sound in your head…ringing, hissing and so on. Think only about your tinnitus in regard to the following questions……..

What does the tinnitus sound like to you? _____ ☐ Constant ☐ Intermittent

In which ear is your tinnitus? ☐ Right ☐ Left ☐ Both ☐ Head ☐ Other

How long ago did you notice the tinnitus? ☐ Past year ☐ 1-3 years ☐ 3-10 years ☐ 10+ years

Do you remember the onset of your tinnitus? ___ Yes ___ No

Was it a sudden or progressive onset? ☐ Sudden ☐ Progressive

Was it related to any other medical or environmental condition? ___ Yes ___ No

*Does your tinnitus pulse with your heartbeat? ___ Yes ___ No *Is

your tinnitus triggered by head or neck movement? ___ Yes ___ No

Is there any one in your family who has/had tinnitus? ___ Yes ___ No

Have you consulted any professional or tried any treatment for your tinnitus? ___ Yes ___ No

If yes, explain_____

Does anything make your tinnitus change? _____

_____

SOUND TOLERANCE

Sound tolerance refers to how you react to sounds in your environment. Think only about your sound tolerance in regard to the following questions…..

Do you use ear protection (earplugs or earmuffs) specifically for tinnitus? ___ Yes ___ No

Do you have a decreased tolerance to sound (are sounds bothersome to you when they seem normal to other people around you)? ___ Yes ___ No

Does sound in your environment….

Cause an increase in your tinnitus?	always	sometimes	never
Cause you to avoid going certain places?	always	sometimes	never
Cause you to feel irritated?	always	sometimes	never

TINNITUS FUNCTIONAL INDEX

Today's Date _____ Your Name: _____

Please read each question below carefully. To answer a question, select *ONE* of the numbers that is listed for that question, and draw a *CIRCLE* around it like this: (10%) or (1.)

I	Over the PAST WEEK…

1. What percentage of your time awake were you **consciously** aware of your tinnitus?

Never Aware ► 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ◄ Always Aware

2. How **strong** or **loud** was your tinnitus?

Not at all strong or loud ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Extremely strong or loud

3. What percentage of your time awake were you **annoyed** by your tinnitus?

None of the time ► 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ◄ All of the time

SC	Over the PAST WEEK…

4. Did you feel **in control** in regard to your tinnitus?

Very much in control ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Never in control

5. How easy was it for you to **cope** with your tinnitus?

Very easy to cope ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Impossible to cope

6. How easy was it for you to **ignore** your tinnitus?

Very easy to ignore ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Impossible to ignore

C	Over the PAST WEEK…

7. Your ability to **concentrate**?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Completely interfered

8. Your ability to **think clearly**?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Completely interfered

9. Your ability to **focus attention** on other things besides your tinnitus?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Completely interfered

SL	Over the PAST WEEK…

10. How often did your tinnitus make it difficult to **fall asleep** or **stay asleep**?

Never had difficulty ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Always had difficulty

11. How often did your tinnitus cause you difficulty in getting **as much sleep** as you needed?

Never had difficulty ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Always had difficulty

12. How much of the time did your tinnitus keep you from **sleeping** as **deeply** or as **peacefully** as you would have liked?

None of the time ► 0 1 2 3 4 5 6 7 8 9 10 ◄ All of the time

Please read each question below carefully. To answer a question, select *ONE* of the numbers that is listed for that question, and draw a *CIRCLE* around it like this: (10%) or (1).

A Over the PAST WEEK, how much has your tinnitus interfered with…

13. Your ability to **hear clearly**?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Completely interfered

14. Your ability to **understand people** who are talking?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Completely interfered

15. Your ability to **follow conversations** in a group or at a meeting?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 Completely interfered

R Over the PAST WEEK, how much has your tinnitus interfered with…

16. Your **quiet resting activities**?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Completely interfered

17. Your ability to **relax**?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Completely interfered

18. Your ability to enjoy **"peace and quiet"?**

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Completely interfered

Q Over the PAST WEEK, how much has your tinnitus interfered with…

19. Your enjoyment of **social activities**?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Completely interfered

20. Your **enjoyment of life**?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Completely interfered

21. Your **relationships** with family, friends, and other people?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Completely interfered

22. How often did your tinnitus cause you to have difficulty performing your **work or other tasks**, such as home maintenance, school work, or caring for children or others?

Never had difficulty ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Always had difficulty

E Over the PAST WEEK…

23. How **anxious** or **worried** has your tinnitus made you feel?

Not at all anxious/worried ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Extremely anxious/worried

24. How **bothered** or **upset** have you been because of your tinnitus?

Not at all bothered/upset ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Extremely bothered/upset

24. How **depressed** were you because of your tinnitus?

Not at all depressed ► 0 1 2 3 4 5 6 7 8 9 10 ◄ Extremely depressed

The Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several Days	More than Half of the Days	Nearly Every Day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed or hopeless	0	1	2	3
3.	Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed. Or, the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals ___ + ___ + ___

Add Total Together _____

10. If you checked off any problems how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

Revised Hearing Handicap Inventory – Screening (RHHI-S)

Instructions: Please check “yes,” “no,” or “sometimes” in response to each of the following items. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear *without* the aid.

		Yes	Sometimes	No
S	Does a hearing problem cause you difficulty when listening to TV or radio?			
S	Does a hearing problem cause you difficulty when attending a party?			
E	Does a hearing problem cause you to feel frustrated when talking to members of your family?			
E	Does a hearing problem cause you to feel left out when you are with a group of people?			
S	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?			
E	Do you feel handicapped by a hearing problem?			
E	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
E	Does a hearing problem cause you to feel uncomfortable when talking to friends?			
S	Does a hearing problem cause you to avoid groups of people?			
S	Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?			

How important is it for you to hear better? Mark an X on the line.

Not Very Important 0----------10 Very Important

How motivated are you to wear and use hearing aids if recommended? Mark an X on the line.

Will not wear 0----------10 Will wear consistently

Assignment of Insurance Benefits/Release of Information

____ Insurance coverage is an agreement between you and your insurance carrier. I hereby assign all insurance benefits to which I am entitled, including Medicare, private insurance, and any other health plans to Elevate Audiology. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance, based on my insurance benefits/contracts. I hereby authorize said assignee to release all information that is necessary to secure payment. Any required physician orders are the responsibility of the patient to receive prior to the appointment time.

Permission for Treatment

____ I hereby voluntarily consent to audiological diagnostics, care, and services by Elevate Audiology, deemed advisable and necessary in the diagnosis and treatment of my audiology condition. I acknowledge that no cures nor guarantees have been made to me as a result of treatment or examination in the office.

Receipt of Notice of Privacy Policy

____ A copy of Elevate Audiology's Privacy Policies was made available to me and I understand its contents. I further acknowledge that a copy of the current notice will be posted in the reception area, website, and any changes will be made available to me.

Education and Marketing

____ I authorize Elevate Audiology to send me educational and/or marketing information on the products and services offered by Elevate Audiology. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

Please check all boxes then sign below

_____ _____

Signature Date

Disclosure of Patient Authorization Record

I authorize that my personal information, hearing healthcare treatment, and financial information may be assessed by and disclosed to the individuals listed (i.e. spouse, family member, caregiver, friend, physicians, etc.).

Name	Relation	Telephone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Confidential Communication

I authorize communications by Elevate Audiology concerning scheduled appointments, treatment, practice information, newsletters, and marketing through the following methods:

Please select all that apply: ___ Phone ___ Text ___ Email ___ Work

Home: (_____) _____-_____ Authorize messages? ___ Yes ___ No
Cell: (_____) _____-_____ Authorize messages? ___ Yes ___ No
Work: (_____) _____-_____ Authorize messages? ___ Yes ___ No

Email: _____

Preferred method for appointment reminders? ___ Phone ___ Text ___ Email ___ Work

Elevate Audiology
Office & Financial Policy

Welcome to our office
Please read this policy carefully and feel free to ask questions regarding any part of the form. Our goal is to provide you excellent hearing care in a comfortable, personal, and cost-effective manner. We hope that you will recognize that our financial policies have been developed to maintain this health care service for our patients and for the community, which means lower fees for you. You can help by paying for your care in a timely manner.

Payment at the time of service is expected.
Payment for services is due in full at the time of service. Payments to Elevate Audiology may be made by cash, check, Visa, MasterCard, or approved financing companies. In order to bill your insurance company for your hearing care, it is important that we obtain complete and accurate information about your primary and supplement insurance coverage, including phone numbers, addresses, and a copy of your cards. We will submit a claim to your insurance as a courtesy to you. If your insurance reimburses us, rather than you, we will refund you or apply the amount to your next visit. Out-of-network insurance beneficiaries and non-covered services are the financial responsibility of the patient.

Verification of Benefits
We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify audiology coverage within your policy. Verification is not a guarantee of payment and **you as the policy holder are primarily responsible to verify benefits.** This can only be done on the day of your appointment if time permits. You are responsible for any coinsurance, deductibles, or fees for non-covered services that may result. Insurance coverage is an agreement between you and your insurance carrier.

Referrals
If your insurance company requires a referral and/or preauthorization/precertification **you are** responsible for obtaining it. We most likely will not be able to obtain a referral on the date of service. An option at this point will be to reschedule the appointment or to pay at the time of service. We suggest you call your primary care doctor at least 24 hours in advance to confirm that your referral has been generated and faxed.

Medicare
We accept assignment from Medicare so all payment from Medicare will be made directly to our office for Medicare-covered services only. We bill Medicare and your supplemental insurance directly. We are required by Federal Law to collect the amount Medicare approves, not just the 20% they do not pay.

No Show and Cancellation Appointments/Late Arrivals
We will reach out to you at least one day before your appointment to confirm your attendance. If we do not reach you, we will leave a message via voicemail or email (if able). Please give at least 24 hours notice if unable to keep an appointment. We reserve the right to charge a $25 fee for missed appointments or appointment cancelled without 24 hour notice. We understand late arrivals happen. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive after your scheduled time. We will need to reschedule if we are unable to accommodate due to late arrival.

Returned Checks
There is a fee (currently $25) for any checks returned by the bank.

Monthly Statement
If you have a balance on your account we will send you a monthly statement. It will show the balance and any new charges to the account. Any unpaid balances older than 30 days may be subject to 1.5% interest fee per month.

Payments
Unless other arrangements are approved by us in writing, the balance on your account is due and paid when the statement is issued. If not paid by the end of the month it will be considered past due.

Past Due Accounts
If your account becomes past due, we will take the necessary steps to collect this debt. This may mean a collections agency. In the event of legal action, you will be responsible for payment of any additional charges equal to the cost of collections, including agency fees, attorney fees, and court costs incurred, as permitted by law governing this transaction.

Effective Date
Once you have signed this document, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Financial Agreement
-I agree to pay promptly all fees and charges for treatments provided to me and/or my family.
-I have read the policies above and understand them.
-I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.
-I authorize Elevate Audiology to release to my insurance carrier any medical information needed to obtain payment for services.
-I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.

Signature: _____ Date: _____