The Scholl Center at Sound IQ
3105 S. Harvard Ave., Tulsa, OK 74135
Office: (918) 508-7601 Fax: (918) 508-7603
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GENERAL FORMS

PATIENT INFORMATION

Full name:_____Preferred name:_____ Today's date:_____

DOB: ____/____/_____ Sex: __ Address:_____ City:_____ State:____ Zip:_____

Primary Case Physician:_____ Referring Doctor:_____

Social Security #:_____-_____-_____ Direct phone #:_____-_____-_____ Secondary phone #:_____-_____-_____

Email address:_____

RESPONSIBLE PARTY INFORMATION

Last name:_____ First name:_____ Middle Initial:___ Social Security #: _____-_____-_____

Relationship to Patient:_____ Home/Cell #: _____-_____-_____ Work #: _____-_____-_____

Employer Name: _____ Employer Phone #:_____-_____-_____

PRIMARY INSURANCE (POLICY HOLDER'S INFORMATION ONLY)

Insurance Company:_____ Subscriber's name:_____ Policy ID #:_____

Subscriber's DOB:____/____/_____ Group #:_____ Relationship to Patient:_____

Policy Effective Date:____/____/_____ Insured's Social Security #:_____-_____-_____ Employer:_____

Employer's #_____-_____-_____

SECONDARY INSURANCE (POLICY HOLDER'S INFORMATION ONLY)

Insurance Company:_____ Subscriber's name:_____ Policy ID #:_____

Subscriber's DOB:____/____/_____ Group #:_____ Relationship to Patient:_____

Policy Effective Date:____/____/_____ Insured's Social Security #:_____-_____-_____ Employer:_____

Employer's #_____-_____-_____

EMERGENCY CONTACT INFORMATION

1. Name:_____ Relationship to Patient:_____ Phone #:_____-_____-_____

MEDICARE PATIENTS

1. Do you receive home health and/or skilled nursing services? ___YES / ____NO

2. If you answered **yes**, please write the name of the entity/facility who provides the services here:

Facility Name:_____ Phone #: _____-_____-_____

BY SIGNING BELOW I CERTIFY THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

Patient/ Guardian Print Name:_____ Relationship to Patient:_____

Patient/Guardian Signature:_____ Date:_____

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CONFIDENTIAL COMMUNICATION REQUEST

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) you have a right to request that communication concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I, _____ (PRINT YOUR NAME) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

Telephone Contact Information:

Home #:_____-_____-_____ ☐ Do ☐ Do Not ☐ Leave messages on my voice mail.

Work #: _____-_____-_____ ☐ Do ☐ Do Not ☐ Leave messages on my voice mail.

Cell #: _____-_____-_____ ☐ Do ☐ Do Not ☐ Leave messages on my voice mail.

I want to recieve ☐ text ☐ email notifications

PLEASE LIST OTHER PERSON THAT MAY BE CONTACTED WITH CONFIDENTIAL INFORMATION

Please note: that if you fail to list parties who can be contacted with confidential information The Scholl Center will not disclose any information about the patient and/or patient treatment including but not limited to: appointment times, test results, medical records, etc.

1. Name:_____ Relationship to Patient:_____ Phone #:_____-_____-_____

2. Name:_____ Relationship to Patient:_____ Phone #:_____-_____-_____

Print Patient Full Name: _____ *DOB:* _____

Sign Patient Full Name: _____ *Date:* _____

If not signed by the patient, please indicate relationship:

☐ Parent or Guardian

☐ Guardian or Conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

☐ Other (specify):_____

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ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT AGREEMENTS RELATED TO TREATMENT

The Scholl Center for Communication Disorders, P.L.L.C. and its employees are here by authorized to collect medical history information, obtain vital signs and perform other routine procedures for purposes of providing care to you. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

CONSENT TO DISCLOSURE OF INFORMATION

Patient medical records and billing information are created and retained by The Scholl Center for Communication Disorders, P.L.L.C. and are accessible to its personnel and medical staff for use in my care. The Scholl Center for Communication Disorders, P.L.L.C. personnel and physicians may use and disclose information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. The Scholl Center for Communication Disorders, P.L.L.C. is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or administrator of a self-insured employer group which is responsible for any part of The Scholl Center for Communication Disorders, P.L.L.C. charges and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. Oklahoma law requires that we advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. You may revoke this consent in writing addressed to The Scholl Center for Communication Disorders, P.L.L.C., except to the extent we have already acted in reliance on it.

ASSIGNMENT OF INSURANCE BENEFITS

You agree that insurance benefits for The Scholl Center for Communication Disorders, P.L.L.C. charges payable to the insured are to be made payable to The Scholl Center for Communication Disorders, P.L.L.C. and that insurance benefits for services provided by the physicians in the hospital setting otherwise payable to the insured are to be made payable to the physician(s) responsible for your care. Any payment received for this episode of care may be applied to any unpaid bill for which you are liable, subject to the rules of coordination of benefits.

PRE-CERTIFICATION POLICY

You understand that The Scholl Center for Communication Disorders, P.L.L.C. will assist with insurance pre-certification requirements which are the responsibility of the policyholder and/or the hospital, but will not assume responsibility for pre-certification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided to you, payment is guaranteed for any amount due for such services provided by The Scholl Center for Communication Disorders, P.L.L.C. Charges for services and goods shall be at The Scholl Center for Communication Disorders, P.L.L.C. billed charges unless otherwise agreed to in writing by The Scholl Center for Communication Disorders, P.L.L.C.

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PAGE 2 OF ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT AGREEMENTS RELATED TO TREATMENT

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PATIENT'S CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or legally authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as the original. Signature of Patient of Patient's Legally Authorized Representative (Documentation Must Be Provided)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by The Scholl Center for Communication Disorders, P.L.L.C. is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this Acknowledgment. The Notice is posted throughout our office and you will be given a copy for your personal use.

I have received a copy of The Scholl Center for Communication Disorders, P.L.L.C. Notice of Privacy Practices:

Patient/ Representative Print:_____

Legal Authority of Representative:_____ Date :_____/_____/_____

Patient Sign:_____ DOB: _____/_____/_____

Basis for refusal, if refused:_____

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Office and Financial Policies

INSURANCE, RESCHEDULING, PAYMENT

Thank you for choosing The Scholl Center for your hearing healthcare needs. We are committed to you and your improved hearing and balance. We want to take this opportunity to inform our patients and their families of our payment policies. This knowledge will help you be better prepared for your appointment.

Insurance

Insurance coverage is an agreement between you and your insurance carrier. We, as healthcare providers, just execute that agreement for you. As a result, it is your responsibility to determine whether or not you have out of network benefits (if The Scholl Center is not a participating provider in your insurance plan), if you require prior authorization or a referral prior to services being provided or if audiology services, and/or hearing aids are covered through your plan. It is important to gather this information prior to your appointment with us. The Scholl Center cannot submit a claim to any insurance carrier if we do not have all the required orders, referrals, or prior authorizations on file. They cannot be obtained after the service is provided. If you are unsure of your coverage specifics, please bring your member benefits handbook with you to the appointment.

Insurance carriers do not cover, in full, all goods and services. While we will verify coverage specifics with your insurance carrier as needed, please understand these are NOT a guarantee of coverage or payment. There may be situations where your insurance carrier does not cover the specific goods or services you are requesting. The Scholl Center commits to providing quality, professional hearing healthcare to all its patients, regardless of their circumstances. When required and possible, we will work to offer an item or service that is within the limits of your insurance coverage.

Cancellation Policy

24 HOUR NOTICE

+ Hearing Assessments
+ Hearing Aid Checks
+ Physical Therapy treatment
+ Physical Therapy evaluation
+ Tinnitus Evaluation
+ Cochlear Implant mappings

$25 fee for no-show appointments and late rescheduling.

72 HOUR NOTICE

+ Balance Evaluation

Due to the length of appointment and necessary withdrawal of certain medications, there will be no exceptions made for balance evaluations.

$125 fee for no-show appointments and late rescheduling.

NEED TO RESCHEDULE

+ Inform

Let us know in the appropriate amount of time if you need to reschedule.

+ Cancellation fee

We reserve the right for a cancellation fee for any no show appointments. This is the patient's responsibility and will not be billed to insurance.

Running Late

We understand that sometimes you may be running late to your appointment. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 10 minutes after your scheduled appointment time. We will try to accommodate you if time allows. Otherwise, we will need for you to come back later in the day if a later appointment is available or reschedule to another date and time.

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Office and Financial Policies

INSURANCE, RESCHEDULING, PAYMENT

Payment

Payment in full is due at the time services are provided. You are responsible to pay all out of pocket expenses such as co-pay, co-insurance, and deductibles on the date the service is provided. All hearing aid related charges must be paid on the date you take possession of any device, accessory, or supplies.

Our Policy

The Scholl Center accepts payment in the form of cash, check, Visa, Mastercard, and Discover. We also offer a third-party credit program through Wells Fargo and AbleTech. *There is a $45 fee for bounced or returned checks.*

It is also the policy of The Scholl Center that we maintain a credit card number on file. This allows us to bill you for an outstanding balance that is not collected within 120 days of the date you were initially billed, while continuing to provide you with care. We will not bill any charges to your credit card without first informing you of this in writing. You then have the right to use an alternative form of payment if you so choose.

It is important that each patient accepts and meets their financial obligations to this practice. Otherwise, we will be unable to provide care to any of our patients. The Scholl Center reserves the right, following 120 days of the initial invoice date, to forward all outstanding balances to either a third party collection agency and/or small claims court. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to us.

☐ *I understand and agree to the office and financial responsibilities of The Scholl Center at Sound IQ.*

☐ *I am the patient.*

Patient Print Name: _____ *DOB:* _____

Patient Signature: _____ *Date:* _____

☐ *I am the parent or guardian of the patient.*

Parent/Guardian Print Name: _____ *DOB (of parent/guardian):*_____

Parent/Guardian Signature: _____ *Date:* _____

*Print patient's full name:*_____ *Patient's DOB:*_____

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Tinnitus Questionnaire

Patient Name:_____ Today's Date:_____

When did you first experience tinnitus?_____

How long have you had tinnitus in its present form? _____

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 HEAD OTHER:_____

Using the following scale, indicate the LOUDNESS of: using this scale: 0 (none) 1 2 3 4 5 6 7 8 9 10 (excruciating)

Your tinnitus right now _____ Your average tinnitus _____ Your tinnitus at its worst _____ Your tinnitus at its least _____

Using the following scale, indicate the PITCH of your tinnitus (It might help to imagine the scale as if it were a piano keyboard)

(Circle) 0 (low pitch) 1 2 3 4 5 6 7 8 9 10 (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: (check one)

_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? (circle)

0 (not bothered) 1 2 3 4 5 6 7 8 9 10 (extreme)

When are you aware of your tinnitus? _____

What percentage of the time during the day or night are you aware of your tinnitus? _____ %

Is there any time during the day when your tinnitus is most troublesome to you?

_at work _ in the morning _ at evening _ when trying to concentrate _ at social activities _ around noise _ other:_____

Do you consider yourself to be a tense person? _Yes _Sometimes _No

Do you feel that emotional or physical stress worsens the tinnitus? _Yes _Sometimes _No

HOW DOES TINNITUS INTERFERE WITH YOUR DAILY 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 to sleep, once awakened? _____

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Tinnitus Questionnaire

Patient Name:_____ Today's Date:_____

HOW DOES TINNITUS INTERFERE WITH YOUR DAILY ACTIVITIES

Do you have a hearing loss? _Yes _No If so which ear? _Left _Right _Both _ Other:_____

Which is more of a problem for you, the hearing difficulty or your tinnitus?

_Hearing difficulty _Tinnitus _Not Sure _ Other:_____

Have you been exposed to loud noise in the past and at present? _Yes _Sometimes _No _ Other:_____

If so, when?: _Military Service _Work _Recreation _ Other:_____

Do you wear ear protection in the presence of loud sounds? _Yes _Sometimes _No

Have you ever worn a hearing aid? _Yes _No If yes, do you currently wear them? _Yes _Sometimes _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 did not have tinnitus?

Please explain:_____

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

Who?_____

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:

Provider	What was Done	Date	Result

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

_____

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TREATMENT HISTORY

Please list the medications you are currently taking.

Medication	Dose	How Often	Prescribing Doctor

TINNITUS INTAKE FORM

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 & Side Effects	5=Worse	NA=Not Applicable
Surgery						
Acupuncture						
Drug Therapy						
Massage						
Masking Therapy						
Biofeedback						
Physical Therapy						
Chiropractic						
Antidepressants						
Relaxation Training/Hypnosis						
Exercise Program						
Psychotherapy or Other						
Counseling						
Dental						
Dietary Management/Nutrition						
Counseling						
Other:						

Are you employed? _Yes _No How many hours per week:_____

What is your occupation?_____

Are you satisfied with your occupation? _Yes _No

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Tinnitus Questionnaire

Patient Name:_____ Today's Date:_____

PROBLEMATIC CHECKLIST

Please check all items that apply 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 labrynthitis
_History of mastoiditis
_History of ear surgery
_Migraine headaches
_Hyperventilation syndrome
_Hypertension
_Cancer
_Dizziness/imbalance or vertigo
_Arthritis
_Heart disease
_Depression
_Increase use of alcohol or drugs
_Fair to poor dietary habits
_Moderate to excessive use of caffeine substances (cola, coffee, chocolate)

_Low back pain
_Low back pain
_Whiplash or neck injury
_Tinnitus is altered by change in position
_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 autoimmune disease (circle)
_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 & neck
_Poor thyroid or parathyroid function

LEGAL

Please check all items and explain that apply to you.

Do you have any 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 _ worker's comp _liability

Please explain:_____

_____

If you have retained an attorney in relation to your tinnitus, please list(Attorney's Name, Address, Telephone Number, City, State & Zip Code)

_____

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Tinnitus Reaction Questionnaire (TRQ)

Patient Name:_____ Today's Date:_____

INSTRUCTIONS

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle, general well-being, etc. Some of the effects below may apply to you, some may not. Please answer all questions by **circling the number** that best reflects how your tinnitus has affected you *over the past week.*

Not at all=**0**
A little of the time=**1**
Some of the time=**2**
A good deal of the time=**3**
Almost all of the time=**4**

1. My tinnitus has made me unhappy.	0	1	2	3	4
2. My tinnitus has made me feel tense.	0	1	2	3	4
3. My tinnitus has made me feel irritable.	0	1	2	3	4
4. My tinnitus has made me feel angry.	0	1	2	3	4
5. My tinnitus has led me to cry.	0	1	2	3	4
6. My tinnitus has led me to avoid quiet situations.	0	1	2	3	4
7. My tinnitus has made me feel less interested in going out.	0	1	2	3	4
8. My tinnitus has made me feel depressed.	0	1	2	3	4
9. My tinnitus has made me feel annoyed.	0	1	2	3	4
10. My tinnitus has made me feel confused.	0	1	2	3	4
11. My tinnitus has "driven me crazy".	0	1	2	3	4
12. My tinnitus has interfered with my enjoyment of life.	0	1	2	3	4
13. My tinnitus has made it hard for me to concentrate.	0	1	2	3	4
14. My tinnitus has made it hard for me to relax.	0	1	2	3	4
15. My tinnitus has made me feel distressed.	0	1	2	3	4
16. My tinnitus has made me feel helpless.	0	1	2	3	4
17. My tinnitus has made me feel frustrated with things.	0	1	2	3	4
18. My tinnitus has interfered with my ability to work.	0	1	2	3	4
19. My tinnitus has led me to despair.	0	1	2	3	4
20. My tinnitus has led me to avoid noisy situations.	0	1	2	3	4
21. My tinnitus has led me to avoid social situations.	0	1	2	3	4
22. My tinnitus has made me feel hopeless about the future.	0	1	2	3	4
23. My tinnitus has interfered with my sleep.	0	1	2	3	4
24. My tinnitus has led me to think about suicide.	0	1	2	3	4
25. My tinnitus has made me feel panicky.	0	1	2	3	4
26. My tinnitus has made me feel tormented.	0	1	2	3	4

TOTAL SCORE:_____

REVISED | WILSON ET. AL 1991

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Tinnitus Questionnaire

Patient Name:_____ Today's Date:_____

INSTRUCTIONS

The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer by circling the question that pertains to you . 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 asleep 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, or 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 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

CLINICIAN USE ONLY

	Y	S	N	
TOTAL PER COLUMN				
	4X	2X	0X	=
TOTAL SCORE		+	+	

FINAL TOTAL

REVISED VERSION

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

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Tinnitus PANAS

Patient Name:_____ Today's Date:_____

This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate number in the space next to that word that describes how your tinnitus makes you feel.Use the following scale to record your answers.

1	2	3	4	5
Very light or not at all	A little	Moderately	Quite a bit	Extremely

1. Interested ____
2. Distressed ____
3. Excited ____
4. Upset____
5. Strong ____
6. Guilty ____
7. Scared ____
8. Irritable ____
9. Alert ____
10. Ashamed ____
11. Inspired____
12. Nervous ____
13. Determined ____
14. Attentive ____
15. Jittery ____
16. Active ____
17. Afraid
18. Hostile ____
19. Enthusiastic ____
20. Proud ____

Additional Comments:

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Tinnitus Functional Index

Patient Name:_____ Today's Date:_____

INSTRUCTIONS

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.

CLINICIAN USE ONLY

SCORE

I. Over the PAST WEEK...

1. What percentage of your time awake were you consciously AWARE OF your tinnitus?
0% (Never) 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% (Aware)

÷ 10 =

2. How STRONG or LOUD was your tinnitus?
0(Absent/Soft) 1 2 3 4 5 6 7 8 9 10 (Extremely Loud)

3. What percentage of your time awake were you ANNOYED by your tinnitus?
0% (None of the time) 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% (All of the time)

÷ 10 =

SC. Over the PAST WEEK...

4. Did you feel IN CONTROL in regard to your tinnitus?
0 (In control) 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?
0 (Easy to cope) 1 2 3 4 5 6 7 8 9 10 (Impossible to cope)

6. How easy was it for you to IGNORE your tinnitus?
0(Very easy to ignore) 1 2 3 4 5 6 7 8 9 10 (Impossible to ignore)

C. Over the PAST WEEK...

7. Your ability to CONCENTRATE?
0(Did not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interfered)

8. Your ability to THINK CLEARLY?
0(Did not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interfered)

9. Your ability to FOCUS ATTENTION on other things besides your tinnitus?
0(Did not interfere) 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?
0(Never) 1 2 3 4 5 6 7 8 9 10 (Completely)

11. How often did your tinnitus cause you difficulty in getting AS MUCH SLEEP as you needed?
0(Never) 1 2 3 4 5 6 7 8 9 10 (Completely)

12. How much of the time did your tinnitus keep you from SLEEPING as DEEPLY or as PEACEFULLY as you would have liked?
0(None of the time) 1 2 3 4 5 6 7 8 9 10 (All of the time)

PAGE 1 TOTAL

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Tinnitus Functional Index

Patient Name: _____ Today's Date: _____

INSTRUCTIONS

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.

CLINICIAN USE ONLY

SCORE

A. Over the PAST WEEK...

13. Your ability to HEAR CLEARLY?
0 (Did not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interfered)

14. Your ability to UNDERSTAND PEOPLE who are talking?
0 (Did not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interfered)

15. Your ability to FOLLOW CONVERSATIONS in a group or at meetings?
0 (Did not interfere) 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?
0 (Did not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interfered)

17. Your ability to RELAX?
0 (Did not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interfered)

18. Your ability to enjoy "PEACE AND QUIET"?
0 (Did not interfere) 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?
0 (Did not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interfered)

20. Your ENJOYMENT OF LIFE?
0 (Did not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interfered)

21. Your RELATIONSHIPS with family, friends and other people?
0 (Did not interfere) 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?
0 (Never had difficulty) 1 2 3 4 5 6 7 8 9 10 (Always)

E. Over the PAST WEEK...

23. How ANXIOUS or WORRIED has your tinnitus made you feel?
0 (Calm) 1 2 3 4 5 6 7 8 9 10 (Anxious)

24. How BOTHERED or UPSET have you been because of your tinnitus?
0 (Calm) 1 2 3 4 5 6 7 8 9 10 (Extremely bothered)

25. How DEPRESSED were you because of your tinnitus?
0 (Not depressed) 1 2 3 4 5 6 7 8 9 10 (Depressed)

PG 1 TOTAL ____ + PG 2 TOTAL ____ = FINAL TOTAL ____