CHAMPLAIN VALLEY
AUDIOLOGY
Hearing & Tinnitus Center

14 Booth Drive
Plattsburgh, NY 12901
518.324.5707

Patient Information

Date _____

Patient Name _____ DOB _____

Mailing Address _____
Street **City/State/Zip code**

Home Phone # _____ ( ) Cell Phone # _____ ( )
Check preferred contact number

Work Phone # _____ ( )

Insurance _____

E-Mail Address: _____

Emergency Contact _____ Phone # _____

Relationship to Patient _____

Primary Care Physician _____

We know that you have a choice in hearing care. Why did you select our office for your visit today?

_____

_____

Consent for Release of Information

Name of Patient:_____DOB:_____

☐ **I HEREBY AUTHORIZE** *Champlain Valley Audiology* to release any and all information contained in the medical record of the above listed patient to any third party payer for whom I may seek payment or reimbursement for expenses related to my office visit. I also authorize *Champlain Valley Audiology* to use Claims Connection to process such claims.

☐ **I HEREBY ASSIGN** and set over all insurance benefits to which I am entitled and which are otherwise payable to me to *Champlain Valley Audiology*.

☐ **I HEREBY AUTHORIZE** *Champlain Valley Audi*ology, having treated me, to release information to other health care facilities or physicians involved in my care.

(please initial all 3 boxes)

I also hereby consent to have *Champlain Valley Audiology* release to the following persons information about my care and treatment.

1. _____
2. _____
3. _____
4. _____
5. _____

_____ _____

Signature of Patient Other Authorized Signature

_____ _____

Date Relationship

CHAMPLAIN VALLEY AUDIOLOGY

_____
Print Name of Client

_____ _____
Print Name of Personal Representative (if applicable) Description of Personal Representative's Authority

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(Notice of Privacy Practices Version Number 1.0, Dated June 18, 2008)

By signing below, I acknowledge that I have been provided a copy of this *Notice of Privacy Practices* and have therefore been advised of how certain health information about me may be used and disclosed by Champlain Valley Audiology and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information and genetic information.

Consent for Treatment, Payment and Health Care Operations

In providing service to you, we create and store health information that identifies you. We understand that this information about you and your health is personal, and we are committed to protecting the privacy of this information. We must obtain your written consent before we treat you, obtain payment or provide services at Champlain Valley Audiology. ***Please read carefully the information below before signing this form.***

Scope of Consent: By signing this consent form, you will permit Champlain Valley Audiology and its staff to use your protected health information for treatment, payment, and normal business operations. You also permit our staff to share your information with other persons or organizations outside this practice that perform payment activities and business operations jointly with the practice.

Notice of Privacy Practices: We have a *Notice of Privacy Practices* that describes these uses and disclosures in detail and we encourage you to read it. We want you to know, however, that the *Notice of Privacy Practices* is subject to change. If it is changed, you may obtain a copy of the revised notice by asking for a copy at your next visit or by calling our office.

Restricting Use and Disclosure: You have the right to ask us to restrict the uses or disclosures of your protected health information. Champlain Valley Audiology is not required to agree to this restriction, but if it does, it will be bound by its agreement unless the information is needed to provide you with emergency treatment or comply with the law.

Revoking consent: You have the right to revoke this consent at any time, except to the extent that Champlain Valley Audiology has provided you with treatment, the practice will be permitted to use or disclose your protected health information to bill for that treatment. To revoke this consent, please contact our office.

I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and health care operations.

I also consent to be contacted via phone and email (if email address has been provided).

_____ _____
Signature of Client or Personal Representative Date

TPA
Tinnitus Practitioners Association

Initial Tinnitus Questionnaire

Hearing

Hearing refers to your ability to detect sounds in your environment or your ability to understand the speech of other. Think only about your hearing in regard to the following questions...

When was your last hearing exam? _____ By whom? _____

What were the results? _____ Recommendations? _____

Have you ever worn hearing aids? ☐Yes ☐No

*Have you experienced a sudden hearing loss? ☐Yes ☐No

Does your hearing....

Limit or hamper your personal or social life?	always	sometimes	never
Cause you to hear people but not understand what they are saying?	always	sometimes	never

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

If you answered ***"tinnitus" as your main problem...***

What percent of the time are you aware of it? _____

How *strong*, or *loud* was your tinnitus, on average, over the last month? "0" would be "no tinnitus and "10" would be "as loud as you can imagine." (Severity)

1 2 3 4 5 6 7 8 9 10

How much has tinnitus *annoyed* you, on average, over the last month" "0" would be "not annoying at all" and "10" would be "as annoying as you could imagine." (Annoyance)

1 2 3 4 5 6 7 8 9 10

How much did tinnitus impact your life, over the last month? "0" would be "not at all"; "10" would be "as much as you could imagine." (Effect)

1 2 3 4 5 6 7 8 9 10

Have you experienced any stressful events within the last 12 months?

_____

_____

_____

Additional Information:

_____

_____

_____

_____

_____

TPA
Tinnitus Practitioners Association

Initial Tinnitus Questionnaire

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……..

How does the tinnitus sound?_____ Constant? Intermittent?

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

How long ago did you notice the tinnitus? ☐Recently ☐1-3 years ☐3-10 years ☐More than 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 other professional or tried any treatment for your tinnitus? ☐Yes ☐No

If yes, explain_____

Does your tinnitus….

Make it difficult to fall asleep?	always	sometimes	never
Make it difficult to concentrate while reading?	always	sometimes	never
Make it difficult to relax in a quiet room?	always	sometimes	never
Make it difficult to focus your attention away from your tinnitus?	always	sometimes	never
Cause you to feel angry?	always	sometimes	never
Cause you to feel stressed?	always	sometimes	never
Cause you to feel sad?	always	sometimes	never

Office Use Only (2)___ (1)___ (0)___ Total_____

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

TPA
Tinnitus Practitioners Association

Initial Tinnitus Questionnaire

Patient Name: _____ **Date:** _____

Reason for today's appointment: _____

Allergies to any medications, plastics, etc.? _____

Current medications: _____

_____

Ear Health History

Have you been exposed to loud sounds/noise? ☐Yes ☐No If yes, explain_____

Have you ever had ear surgery? ☐Yes ☐No If yes, ear? ☐Right ☐Left type?_____

Have you ever had any head/ear trauma? ☐Yes ☐No If yes, explain_____

Have you ever taken medication that had a toxic effect on your hearing? ☐Yes ☐No If yes, type?_____

*Have you experienced any drainage from your ear(s) within the last 90 days? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

*Do you suffer from pain or discomfort in your ear(s)? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

Do you have temporomandibular joint (TMJ) disorder? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

Do you have a congenital or traumatic deformity of the ear? ☐Yes ☐No

If yes, describe: _____

Do you often have significant cerumen (earwax) accumulation in your ear canal?

☐Right ☐Left ☐Both ☐Neither

*Do you suffer from acute or chronic dizziness? ☐Yes ☐No

Please list all major surgeries (Past 10 years:

_____

_____

_____

Please list any serious illnesses (Past 10 years):

_____

_____

_____

Are you diabetic? ☐Yes ☐No

Do you have high blood pressure? ☐Yes ☐No

Champlain Valley Audiology

Medication Log

Name:_____ **DOB:**_____

Please be sure to complete all four columns

Medication Names: Includes prescription, over The counter, vitamins & Herbal supplements	**Dosage**	**Frequency**	**How is it taken (orally, Injection, patch, Inhaler, etc.**

In order to stay compliant with new insurance regulations, we are required to ask you for a list of your prescriptions and over the counter medications, herbal supplements and vitamins.

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...**	*Did not interfere*										*Completely interfered*
	13. Your ability to **HEAR CLEARLY**?	0	1	2	3	4	5	6	7	8	9	10
	14. Your ability to **UNDERSTAND PEOPLE** who are talking?	0	1	2	3	4	5	6	7	8	9	10
	15. Your ability to **FOLLOW CONVERSATIONS** in a group or at meetings?	0	1	2	3	4	5	6	7	8	9	10

R	**Over the PAST WEEK, how much has your tinnitus interfered with...**	*Did not interfere*										*Completely interfered*
	16. Your **QUIET RESTING ACTIVITIES**?	0	1	2	3	4	5	6	7	8	9	10
	17. Your ability to **RELAX**?	0	1	2	3	4	5	6	7	8	9	10
	18. Your ability to enjoy **"PEACE AND QUIET"**?	0	1	2	3	4	5	6	7	8	9	10

Q	**Over the PAST WEEK, how much has your tinnitus interfered with...**	*Did not interfere*										*Completely interfered*
	19. Your enjoyment of **SOCIAL ACTIVITIES**?	0	1	2	3	4	5	6	7	8	9	10
	20. Your **ENJOYMENT OF LIFE**?	0	1	2	3	4	5	6	7	8	9	10
	21. Your **RELATIONSHIPS** with family, friends and other people?	0	1	2	3	4	5	6	7	8	9	10

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 or worried ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely anxious or worried*

24. How **BOTHERED** or **UPSET** have you been because of your tinnitus?

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

25. 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*

TINNITUS FUNCTIONAL INDEX

Today's Date _____ Your Name _____

Month / Day / Year *Please Print*

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*