Tinnitus and Hyperacusis Program

We thank you for your inquiry into the Tinnitus and Hyperacusis Program.

Important
If you are experiencing a sudden loss of hearing, drainage from the ears or facial numbness or paralysis, contact the Ear, Nose and Throat Clinic for an appointment **immediately** at 414-805-5580.

Is Your Primary Concern Hearing Loss?
If your primary concern is hearing loss, and your tinnitus is not distressing, you do not need to complete the tinnitus packet. We recommend you begin with a comprehensive hearing evaluation. Call 414-805-5587 to schedule a hearing evaluation.

Our Tinnitus and Hyperacusis Program begin in 2008 to help people who are seeking help for distressing noises in the ears or head and sound sensitivity issues. We recognize that tinnitus and sound sensitivity are troubling and life-changing conditions and wish to get you on the road to recovery in the most efficient manner possible.

So we may best serve your individual needs, please complete the enclosed history forms and questionnaires. You can return them via mail, fax or MyChart. Once the forms are received and reviewed, we will call you to set up an appointment. At the time we call, we will tell you which tests and appointments are appropriate for you and which audiologist will best meet your specific needs.

Please send any outside records specifically related to your history of tinnitus or sound sensitivity, such as hearing tests and any pertinent medical office notes along with the completed paperwork.

Also included is a billing agreement that we ask you to read, sign and return to us along with the questionnaires. All forms need to be returned before an appointment can be scheduled. You can expect a call within a week of the date the completed questionnaires are received.

We look forward to serving you!

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Tinnitus Management Appointment Agreement

This packet is for the Tinnitus and Hyperacusis Program management/consultation appointment to guide you in how to manage the distress of your symptoms and reduce the impact symptoms have on your life. Our team **may** recommend this appointment. This is determined once we have received and reviewed your completed paperwork, including this signed patient agreement.

After reading the attached materials, please initial each of the items below and sign at the bottom of the page.

I understand that:

____ The purpose of the appointment is to educate me in establishing a tinnitus or hyperacusis management program. The appointment is not intended to result in a cure for my tinnitus.

____ There is no specific insurance coding for tinnitus counseling. My insurance company will not be billed, and the Audiology Clinic will not accept insurance payment for this appointment.

_____I will pay for the appointment on the date of service. The appointment fee is $180.

____ We require a 24-hour cancellation notice due to the length of these appointments. If a 24-hour notice is not provided, we will consider it a **no-show** appointment and, at our discretion, we may not reschedule the appointment.

____ We will bill any test procedure for tinnitus, including hearing tests, to your insurance. It is your responsibility to determine with your insurance company if the hearing testing is covered, including deductibles and co-pay.

I agree to the terms as noted above.

_____	_____	_____
Patient Name (printed)	**Patient/Guardian Signature**	**Date**

Important: Insurance does not cover the cost of tinnitus counseling and management. The cost for this service is $180. Follow-up counseling is billed at $120 per visit. You will be responsible for the cost of services not covered by your health insurance. These fees do not cover the cost of hearing aids, earplugs and/or sound generating devices.

NOTE: The purpose of our program is to help guide patients in managing the distress of their symptoms. If you are involved in any **legal action** regarding your symptoms, our doctors and clinicians are not available as expert witnesses or to provide any legal guidance or opinions.

Tinnitus History Questionnaire

Name: _____ Date of birth: _____ Date completed: _____

Phone: _____ Email: _____

Who referred you?

Physician**:** _____

Self (how did you hear about our program?): _____

Background questions

Home/family situation (list who lives with you): _____
_____
_____

Work situation: Current or previous work history? _____
_____
_____

Retired? (circle) Yes No; if yes, when: _____

Have you had any extended periods of sick leave within the last six months? (circle) Yes No

If yes, part time or full time? (circle one)

Nature of the Tinnitus

How does the tinnitus sound? □ Ring □ Buzz □ Hum □ Roar □ Tone □Static □ Music
□ Other (describe): _____

Usual site of the tinnitus? □Both ears □Right ear □Left ear □Central
□Right worse than left □Left worse than right

What makes your tinnitus worse? _____

What makes your tinnitus better? _____

Is your tinnitus constant? (circle) Yes No

Does your tinnitus fluctuate in intensity? (circle) Yes No

Does your tinnitus pulsate? (circle) Yes No If yes, does it pulse with your heartbeat? Yes No

Can you change your tinnitus? (circle) Yes No

If yes, how? Movement of □ Jaw □ Neck □ Head □Eyes □ Other: _____

Which ear? (circle) Right Left

Tinnitus History

When did you first become aware of your tinnitus? _____

_____

When did your tinnitus become bothersome? _____

_____

What do you consider to have started the tinnitus? _____

_____

Who have you consulted about your tinnitus? _____

_____

What have previous professionals said your tinnitus is due to? _____

_____

What treatments have you tried for your tinnitus? (Check all that apply.)

□ None □ Hearing aid □ Masker/sound generator
□ TRT □ Counseling (CBT) □ Music or other sound
□ Other (Please explain.) _____

How successful did you find these treatments? _____

_____

Do you now, or have you ever had the following: (Check all that apply.)

□Noise exposure (past or present)?
(Gunfire, military, music concerts, noisy job, hobbies or home activities)
□Hearing loss
□Family member with hearing loss
□Head injuries
□Neck injuries/problems
□Ear surgery
□Ear infections
□Diagnosis of ear disease

Do you experience **<u>now (or recently)</u>**:

□Vertigo/dizziness/imbalance
□ Ear pain/pressure/fullness

_____

If you checked “yes” to any of the above, please write details/comments in the lines below.

_____

Other diagnoses and medical history:

- □History of temporomandibular joint (TMJ) disease
- □Teeth clenching/grinding
- □Dental work associated with onset or increase of tinnitus
- □High blood pressure
- □Heart disease
- □Kidney disease
- □Liver disease
- □Treatment with chemotherapy or radiation
  Type _____
- □Depression/anxiety
- □Contact with psychiatrist/psychologist
- □Diabetes

□Other diagnosed diseases/syndromes: (e.g., Lyme disease, fibromyalgia, multiple sclerosis):

_____

If you checked "yes" to any of the above, please write details/comments in the line below.

_____

Hearing aid history:

Do you currently/have you ever worn hearing aids? (circle) Yes No

If so, what brand/type do you have? _____

How old are your current aids? _____

Do they help your hearing? _____

Do you notice a change in your tinnitus with your hearing aids in? (circle) Yes No

Effects of Tinnitus

Does your tinnitus prevent you from getting to sleep or staying asleep? (circle) Yes No

Have you been prescribed any of the following types of medications (sleeping pills, anxiety medications, etc.) (circle) Yes No

List: _____

Describe how tinnitus has affected your home life? _____

_____

Describe how tinnitus has affected your social life? _____

_____

Describe how tinnitus has affected your work life? _____

_____

What activities/places do you avoid because of your tinnitus? _____

_____

Describe how tinnitus has affected your enjoyment of life? _____

_____

What is your biggest concern or fear regarding your tinnitus? _____

_____

Please write in the lines below anything else you would like to add that might be relevant to understanding what caused your tinnitus or how you feel about your tinnitus.

_____

_____

_____

What are your goals for coming to our clinic?

_____

_____

Are there any pending legal actions regarding your tinnitus, sound sensitivity or hearing loss?

(circle) Yes No

Tinnitus Handicap Inventory

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

	No (0)		**Sometimes** (2)	(3)	**Yes** (4)
1. Because of your tinnitus, it is 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 feel confused?	☐	☐	☐	☐	☐
5. Because of your tinnitus, do you feel desperate?	☐	☐	☐	☐	☐
6. Do you complain a great deal about your tinnitus?	☐	☐	☐	☐	☐
7. Because of your tinnitus, do you have trouble falling asleep at night?	☐	☐	☐	☐	☐
8. Do you feel as though you cannot escape your tinnitus?	☐	☐	☐	☐	☐
9. Does your tinnitus interfere with your ability to enjoy your activities (such as going out to dinner or to the movies)?	☐	☐	☐	☐	☐
10. Because of your tinnitus, do you feel frustrated	☐	☐	☐	☐	☐
11. Because of your tinnitus, do you feel 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 problem has placed stress on your relationships with members of your family and friends?	☐	☐	☐	☐	☐
18. Do you find it difficult to focus your attention away from your tinnitus and on 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 that 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?	☐	☐	☐	☐	☐

Over the past week, what percentage of time were you aware of your tinnitus? _____

During the time you were aware of your tinnitus, what percentage of time was it bothersome? _____

Tinnitus Functional Questionnaire

Adapted from Tinnitus Primary Function Questionnaire

Please indicate your agreement with each statement on a scale from 0 (completely disagree) to 100 (completely agree).

Tinnitus: Internal sounds in your ears or head

Item	Statement	Your score (0-100)	Average
1	I feel like my tinnitus makes it difficult for me to concentrate on some tasks		
2	I have difficulty focusing my attention on some important tasks because of tinnitus.		
3	My inability to think about something undisturbed is one of the worst effects of my tinnitus		
4	My emotional peace is one of the worst effects of my tinnitus		
5	I am depressed because of my tinnitus		
6	I am anxious because of my tinnitus		
7	I am tired during the day because my tinnitus has disrupted my sleep		
8	I lie awake at night because of my tinnitus		
9	When I wake up in the night, my tinnitus makes it difficult to get back to sleep		

Hearing loss: Difficulty understanding speech and environmental sounds

Item	Statement	Your score (0-100)	Average
1	It's hard for me to understand what others are saying in noisy/crowded places		
2	I have a difficult time understanding what people are saying on television or movies		
3	It's hard for me to participate in group conversations because I can't understand what others are saying		

Sound Sensitivity: Sensitive to external sounds in your environment (NOT tinnitus)

Item	Statement	Your score (0-100)	Average
1	I feel like my sound sensitivity (hyperacusis) makes it difficult for me to enjoy my life		
2	I must avoid many situations because of my sound sensitivity (hyperacusis)		
3	My inability to tolerate everyday sounds is one of the worse effects of my sound sensitivity (hyperacusis)		

Holmes-Rahe Life Stress Inventory

Complete the following life stress inventory. This will help us to determine how stress may impact your health and be contributing to your tinnitus.

Read each of the events listed below, and check the box next to any event which has occurred in your life in the last 12 months. There are no right or wrong answers. The aim is to identify which events you have experienced lately.

Life Events	**Change Units**	
Death of spouse/child	100	☐
Divorce	73	☐
Marital separation	65	☐
Jail term	63	☐
Death of close family member	63	☐
Personal injury or illness	53	☐
Marriage	50	☐
Fired at work	47	☐
Marital reconciliation	45	☐
Retirement	45	☐
Change in health of a family member	44	☐
Pregnancy	40	☐
Sex difficulties	39	☐
Gain of new family member	39	☐
Business readjustment	39	☐
Change in financial state	38	☐
Death of close friend	37	☐
Change to different line of work	36	☐
Change in number of arguments with spouse	35	☐
Mortgage over $500,000	31	☐
Foreclosure of mortgage or loan	30	☐
Change in responsibilities at work	29	☐
Child leaving home	29	☐
Trouble with in-laws	29	☐
Outstanding personal achievement	28	☐
Spouse begins or stops work	26	☐
Begin or end school	26	☐

Change in living conditions	25	☐
Revision in personal habits	24	☐
Trouble with boss	23	☐
Change in work hours or conditions	20	☐
Change in residence	20	☐
Change in schools	20	☐
Change in recreation	19	☐
Change in church activities	19	☐
Change in social activities	18	☐
Mortgage or loan less than $100,000	17	☐
Change in sleeping habits	16	☐
Change in number of family get-togethers	15	☐
Change in eating habits	15	☐
Vacation	13	☐
Christmas alone	12	☐
Minor violations of the law	11	☐
None of the above apply:	0	☐

Add other stressors you have experienced in the past year that are not included above or additional information you would like to add:

_____

_____

Fax or Mail Your Form and Records

Send us your completed form and any outside records specifically related to your history of tinnitus — such as hearing tests or office notes. You or your doctor's office may send them via fax or mail to the contact information below.

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In addition to tinnitus (internal sounds), some people experience sensitivity to sounds in their environment (external sounds) referred to as hyperacusis or misophonia. If you feel you are sensitive to sounds that others are not sensitive to or are now sensitive to sounds you were able to tolerate in the past, complete the additional forms in the hyperacusis packet.