PATIENT INTAKE FORM

THANK YOU for scheduling your appointment with us!

Name: _____ **Nickname:** _____

Address: _____ **City, State, Zip Code:** _____
For apartments, please include apartment number.

Phone Numbers Cell: _____ **Home:** _____ **Work:** _____

DoB: _____ **Email Address:** _____

If you live in a senior citizen facility, please tell us which one: _____

How do you prefer to be notified of appointments? Text: _____ Email: _____ Cell: _____ Home Ph: _____

Sex: M F O Marital Status: Married Single Widow Divorced Domestic Relationship Other

Employment: Full Time Part Time Retired Student Other

Language: Is English your first language? Yes No If not, are you fairly fluent in English? Yes No

Primary Care Physician: _____ City/State: _____

Did a physician refer you to us? _____ If so, who was it? _____

May we share the results of your appointments with your primary care physician: Yes _____ No _____

Are you currently receiving hospice care? Yes _____ No _____

Please rate your hearing on a scale of 1-10 **without the use of aids**. 1 being cannot hear at all and 10 being you can hear great. _____.

If applicable, please rate your hearing on a scale of 1-10 **with the use of aids.** 1 being cannot hear at all and 10 being you can hear great. _____.

Your information with us is kept private and confidential. If there is a loved one, family member, or caregiver that you approve to have your information released to, please specify their information below. Otherwise, information about you and your care **will not** be released.

Full Name:	Relation and Phone Number:	Check if POA
_____	_____	☐
_____	_____	☐

How did you learn about us? _____

If referred by a patient or friend, can we use your name in a thank you note to them? Yes No

24 Hour Appointment Cancellation Policy

If you miss your appointment, cancel, or change your appointment with less than 24 hours' notice, you will be charged: $55 for appointments 30 minutes and under
$85 for all other appointments

This policy is in place out of respect for our audiologist and patients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from possibly getting the care that they may need.

By signing below, you acknowledge that you have read and understand the Cancellation Policy of Now Hear This® as described above.

We thank you for your understanding and cooperation.

Date: _____ _____
Patient Signature

Agreement & Authorization

I understand that if services provided by Now Hear This® are not authorized or paid for by my insurance company, I will be responsible for all charges incurred. I hereby agree to pay in full any and all charges for services rendered that are not covered by my health insurance company.

Now Hear This® is authorized to release to my insurance company any and all medical information necessary to process my claim for reimbursement of charges incurred for services rendered or for the purpose of determining continued eligibility. Now Hear This® is also authorized to release medical information to my referring physician or health care provider to monitor progress.

Now Hear This® is also authorized to release information about my care and appointments to providers and/or specialist that they may need to refer me to for additional care.

I hereby authorize and direct my insurance company or companies to make direct payment to Now Hear This® under any and all applicable coverage, including major medical, for covered charges for services rendered.

I further understand that Now Hear This® follows all HIPAA guidelines. The HIPAA guidelines are available for my review any time that I request them. By reading and signing this document, I agree that I have been given an opportunity to review the HIPAA guidelines.

I give permission to Now Hear This® to contact me by phone, email, mail, and/or text for appointment reminders, hearing aid care/repair information, as well as marketing and promotions on new hearing aid technology.

Date: _____ _____
Patient Signature

Please provide your health insurance card(s) and driver's license for your file.

Now Hear This® HEARING AIDS & AUDIOLOGY

Name: _____ DOB: _____ Date: _____

New Patient Medical History

What are your goals for today's visit? _____

Yes	No	Please check Yes or No for the following:
		Have you previously had a hearing test? If yes, when? _____
		Have you ever had an ear surgery or ear infection?
		Have you noticed a change in your hearing in the last year?
		Have you ever had blood or drainage from your ear(s)?
		Are you experiencing ear pain, pressure, or fullness?
		Do you have sinus issues? Please explain: _____
		Have you been exposed to loud noise at any point in your life? Machine/ tools __ Motorcycles __ Firearms __ Music __ Other ___
		Does anyone in your family have hearing loss?
		Have you ever experienced vertigo or had balance issues?
		Have you had a fall in the past year?
		Do you wear, or have you ever worn, hearing aids?
		Do you experience Tinnitus symptoms? Right ___ Left ____ Both Ears ____ - What does it sound like? _____ Constant ___ Intermittent ___ - How bothersome are your Tinnitus symptoms? 1 ---------- 10 *Minimal* *Severe*
		Are you currently on any blood thinner medications?
		Do you have a history of smoking?
		Have you ever experienced a head trauma or traumatic brain injury (TBI)?
		Have you ever had an MRI or scan of your brain, face, and/or ears?

Please mark any that you have had or been diagnosed with:

___ Stroke
___ Cognitive Decline
___ Dementia
___ Diabetes
___ Bell's Palsy
___ Meniere's Disease
___ Acoustic Neuroma
___ Autoimmune Disease
___ Pneumonia
___ Tuberculosis
___ Lyme Disease
___ High Blood Pressure
___ High Cholesterol

Are you currently on any medications? If so, please list (or provide list):

HHIA Questionnaire

The purpose of this scale is to identify the problems your hearing difficulties may be causing you. Check **YES, SOMETIMES, or NO** for each question. Do not skip a question if you avoid a situation because of your hearing difficulty. If you use a hearing aid, please answer the way you hear **without** your device. Thank you!

		Yes	Some-times	No
	Does a hearing difficulty…			
S-1	…cause you to use the phone less?			
E-2	…make you feel embarrassed when meeting new people?			
S-3	…cause you to avoid groups of people?			
E-4	…make you feel irritated?			
E-5	…cause frustration when talking to family?			
S-6	…cause issues when attending a party?			
S-7	…impact your understanding of other people in the workplace or other daily activities?			
E-8	Do you feel handicapped by a hearing difficulty?			
S-9	…create issues with friends or family?			
E-10	...cause frustration when with people in the workplace or other daily activities?			
S-11	…impact your understanding in theaters?			
E-12	…cause you to be nervous?			
S-13	…cause you to visit friends or relatives less?			
E-14	…cause you to have arguments with family?			
S-15	…cause problems when listening to TV?			
S-16	…cause you to shop less than you would like?			
E-17	…upset you at all?			
E-18	…cause you to want to be by yourself?			
S-19	…make you to talk to your family less?			
E-20	Do you feel hearing difficulties limit your personal or social life?			
S-21	…cause issues when in a restaurant?			
E-22	…cause you to feel depressed?			
S-23	…cause you to watch less TV than you want?			
E-24	…make you feel uncomfortable when talking to friends?			
E-25	…make you to feel left out when with a group of people?			

Tick the box beside the reply that is closest to how you have been feeling in the past week. Don't take too long over you replies: your immediate is best.

	I feel tense or 'wound up'		**I feel as if I am slowed down:**
	Most of the time		Nearly all of the time
	A lot of the time		Very often
	From time to time, occasionally		Sometimes
	Not at all		Not at all
	I still enjoy the things I used to enjoy:		**I get a sort of frightened feeling like "butterflies" in the stomach:**
	Definitely as much		Not at all
	Not quite so much		Occasionally
	Only a little		Quite often
	Hardly at all		Very often
	I get a sort of frightened feeling as if something awful is about to happen:		**I have lost interest in my appearance:**
	Very definitely and quite badly		Definitely
	Yes, but not too badly		I don't take as much care as I should
	A little, but it doesn't worry me		I may not take quite as much care
	Not at all		I take just as much care as ever
	I can laugh and see the funny side of things:		**I feel restless as I have to be on the move:**
	As much as I always could		Very much indeed
	Not quite so much now		Quite a lot
	Definitely not so much now		Not very much
	Not at all		Not at all
	Worrying thoughts go through my mind:		**I look forward with enjoyment to things:**
	A great deal of the time		As much as I ever did
	A lot of the time		Rather less than I used to
	From time to time, but not too often		Definitely less than I used to
	Only occasionally		Hardly at all
	I feel cheerful:		**I get sudden feelings of panic:**
	Not at all		Very often indeed
	Not often		Quite often
	Sometimes		Not very often
	Most of the time		Not at all
	I can sit at ease and feel relaxed:		**I can enjoy a good book or radio or TV program:**
	Definitely		Often
	Usually		Sometimes
	Not often		Not often
	Not at all		Very seldom

Tinnitus and Hearing Survey

	No, **not** a problem	Yes, a **small** problem	Yes, a **moderate** problem	Yes, a **big** problem	Yes, a **very big** problem	
A. Tinnitus						
Over the last week, tinnitus kept me from sleeping.	0	1	2	3	4	
Over the last week, tinnitus kept me from concentrating on reading.	0	1	2	3	4	
Over the last week, tinnitus kept me from relaxing.	0	1	2	3	4	Grand Total
Over the last week, I couldn't get my mind off of my tinnitus.	0	1	2	3	4	☐
	___	___	___	___	___	
		Total of each column				
B. Hearing						
Over the last week, I couldn't understand what others were saying in noisy or crowded places.	0	1	2	3	4	
Over the last week, I couldn't understand what people were saying on TV or in movies.	0	1	2	3	4	
Over the last week, I couldn't understand people with soft voices.	0	1	2	3	4	Grand Total
Over the last week, I couldn't understand what was being said in group conversations.	0	1	2	3	4	☐
	___	___	___	___	___	
		Total of each column				
C. Sound Tolerance						
Over the last week, sounds were too loud or uncomfortable for me when they seemed normal to others around me.*	0	1	2	3	4	

If you responded 1, 2, 3, or 4 to the statement above:

Please list two examples of sounds that are too loud or uncomfortable for you, but seem normal to others:

_____

_____

*If sounds are too loud for you while wearing hearing aids, please tell your audiologist.

For office use only (II): ☐M ☐H ☐N

Tinnitus Handicap Inventory

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus.

To fill out the questionnaire, circle “Yes,” “No” or “Sometimes” next to each question.

F1	Because of your tinnitus is it difficult for you to concentrate?	Yes	No	Sometimes
F2	Does the loudness of your tinnitus make it difficult for you to hear people?	Yes	No	Sometimes
E3	Does your tinnitus make you angry?	Yes	No	Sometimes
F4	Does your tinnitus make you confused?	Yes	No	Sometimes
C5	Because of your tinnitus are you desperate?	Yes	No	Sometimes
E6	Do you complain a great deal about your tinnitus?	Yes	No	Sometimes
F7	Because of your tinnitus do you have trouble falling to sleep at night?	Yes	No	Sometimes
C8	Do you feel as though you cannot escape your tinnitus?	Yes	No	Sometimes
F9	Does your tinnitus interfere with your ability to enjoy social activities (such as going out to dinner, to the cinema)?	Yes	No	Sometimes
E10	Because of your tinnitus do you feel frustrated?	Yes	No	Sometimes
C11	Because of your tinnitus do you feel that you have a terrible disease?	Yes	No	Sometimes
F12	Does your tinnitus make it difficult to enjoy life?	Yes	No	Sometimes
F13	Does your tinnitus interfere with your job or household responsibilities?	Yes	No	Sometimes
F14	Because of your tinnitus do you find that you are often irritable?	Yes	No	Sometimes
F15	Because of your tinnitus is it difficult for you to read?	Yes	No	Sometimes
E16	Does your tinnitus make you upset?	Yes	No	Sometimes
E17	Do you feel that your tinnitus has placed stress on your relationships with members of your family and friends?	Yes	No	Sometimes
F18	Do you find it difficult to focus your attention away from your tinnitus and on to other things?	Yes	No	Sometimes
C19	Do you feel that you have no control over your tinnitus?	Yes	No	Sometimes
F20	Because of your tinnitus do you often feel tired?	Yes	No	Sometimes
E21	Because of your tinnitus do you feel depressed?	Yes	No	Sometimes
E22	Does your tinnitus make you feel anxious?	Yes	No	Sometimes
C23	Do you feel you can no longer cope with your tinnitus?	Yes	No	Sometimes
F24	Does your tinnitus get worse when you are under stress?	Yes	No	Sometimes
E25	Does your tinnitus make you feel insecure?	Yes	No	Sometimes

C.O.A.T. Questionnaire

Name: ____________________________________ **Date**: ___________________

Should we find that you have a hearing loss, your answers will help us understand your communication needs, your personal preferences, and your expectations. This will allow us to better serve you and your listening needs.

1. List the top three situations where you would most like to hear better. *(Some examples: hearing my children at the dinner table, hearing my friends when out at a restaurant, being able to hear the television without turning the volume up, communicating with my spouse).*
   A. ______________________________
   B. ______________________________
   C. ______________________________

2. How important is it for you to hear better? Mark an X on the line.
   Not very important - ***Very important***

3. How motivated are you to wear and use hearing aids every day? Mark an X on the line.
   Not very motivated - ***Very motivated***

4. What is your most important consideration regarding hearing aids? Rank the following factors in order with 1 as the most important and 4 as the least important. Place an X on the line if the item has no importance to you at all.
   _____ Hearing aid size and the ability of others not to see the hearing aids
   _____ Improved ability to hear and understand speech
   _____ Improved ability to understand speech in noisy situations (e.g., restaurants)
   _____ Cost of the hearing aids

6. There is a wide range in hearing aid prices. The cost of hearing aids depends on a variety of factors including the sophistication of the circuitry and the amount of noise reduction. Please select the price range are you most comfortable spending for hearing devices providing you with better hearing? Pricing listed below is for a pair of hearing devices. **Mark an X on the line.**

   ____ *Essential ($2800 - $3500)* ____ *Good ($3500 - $4500)*

   ____ *Better ($4600 - $5500)* ____ *Best ($5600 - $6800)*

THANK YOU for answering these questions.
Your responses will assist us in providing you with the best hearing healthcare!