Audiology & Hearing
SERVICES OF CHARLOTTE

Today's Date:_____

Full Name (circle one): Mr. Ms. Mrs. Dr.

_____

Date of Birth: _____

PERSONAL HISTORY - ADULT

Age: _____

Preferred Name: _____ ❑ Male ❑Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

E-mail Address: _____

What is the best way to reach you? ❑ Home Phone ❑ Cell Phone ❑ E-mail ❑ Other: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ _____

Accompanied by: _____ Relationship: _____

Employer: _____ Your Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Business Phone: (____) _____ Is it OK to call at work?: ❑ Yes ❑ No

Family Physician: _____ Physician Phone Number: (____) _____

How did you hear about our practice? ❑ Physician ❑ Yellowbook ❑ Radio ❑ Website ❑ Google ❑ Verizon ❑ Yellow Pages ❑ Other: _____

Please list persons (family members, doctors, etc.) with whom you give us permission to discuss your health information, send reports, and schedule future appointments:

○ Referring Physician - _____ ○

Primary Care Physician - _____ ○

Other Physician - _____ ○

Family Member (s) - _____ ○

Other - _____

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List power of attorney's contact information (if applicable) _____

MEDICAL HISTORY

Please check all medical symptoms that apply:

	Left Ear	Right Ear	Both	Dates of occurrence:
Ear Pain				
Ear Infections				
Ear popping				
Ear Surgery				
Ear Tubes				
Ear Drainage				
Ears Ringing				
Trauma (Head/ Ear)				
Ear Deformity				
Dizziness or unsteadiness				

Have you had any of the following? Please check all of those that apply.

❑ Alzheimer's/ Dementia	❑ Arthritis	❑ Cancer
❑ Depression/Anxiety	❑ Diabetes	❑ Heart problems
❑ High Blood Pressure	❑ Measles	❑ Meningitis
❑ Multiple Sclerosis	❑ Mumps	❑ Stroke/TIA
❑ Decreased Feeling in Fingers	❑ Other_____	❑ Other_____

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Please check all medical symptoms and conditions that apply:	YES	NO
Eye problems (such as blurred or double vision or pain)		
Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues)		
Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations)		
Respiratory issues (such as shortness of breath, cough, wheezing		
Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain):		
Musculoskeletal issues (such as joint pain, swelling, recent trauma)		
Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness):		
Psychiatric issues (such as depression, anxiety, compulsions)		
Endocrine symptoms (such as frequent urination, hot flashes)		
Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands)		
Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency)		

List any operations _____

Other chronic illnesses _____

Any drug or other allergies (including latex/plastics)_____

Do you currently use any recreational drugs? ❑ Yes ❑ No
If yes, what drugs? _____
How often? ❑ Daily ❑ Weekly ❑ Monthly ❑ Occasionally ❑ Rarely

Do you currently drink alcohol beverages? ❑ Yes ❑ No
If yes, how often? ❑ Daily ❑ Weekly ❑ Monthly ❑ Occasionally ❑ Rarely

Have you smoked a cigarette, cigar, e-cig (vape), tobacco, one or more times in the past 24 months? ❑ Yes ❑ No

If yes, how often in the past 24 months? _____Amount of use per day? _____

If yes, what do you use? ❑ Cigarette ❑ Cigar ❑ Pipe ❑ E-cig (vape) ❑ Other_____

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Please list all current medications or attach a list:

NAME	DOSE (MG)	FREQUENCY (Example:1 a day)	DELIVERY METHOD (Example: Oral , Shot, Eye drops)

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Today's Date:_____

Full Name: _____

Nature of the Tinnitus

How does the tinnitus sound?_____

Usual site of the tinnitus? (circle)

Left = Right Left worse than Right Right worse than Left Central

Is the tinnitus constant or intermittent?_____

Does the tinnitus fluctuate in intensity or loudness? _____

What makes your tinnitus worse?_____

What makes your tinnitus better?_____

Tinnitus History

When did you first become aware of your tinnitus?_____

When did your tinnitus first become disturbing?_____

Under what circumstances did the tinnitus start?_____

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?

❑None ❑Hearing Aid ❑ Masker

❑TRT ❑Counselling ❑ Music Therapy

❑ Other – Please Comment_____

How successful did you find these treatments??_____

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Have you ever:

	Y/N	Details/Comments
Been exposed to gunfire or explosion?		
How often were you exposed?		
Did you wear hearing protection?		
Attended loud events? (e.g., concerts, clubs)		
Had any noisy jobs?		
Had any noisy hobbies or home activities?		
Had any head injuries or concussion?		
Had any operations involving your ear or head?		
Used solvents, thinners or alcohol based cleaners?		
Taken any of the following medications: Quinine, Quinidine, Streptomycin, Kanamycin, Dihydrostreptomycin, Neomycin		

Do You:

	Y/N	Details/Comments
Have loose dentures, jaw pain or grinding and clicking sensations in the jaw?		
Regularly take aspirin?		
Have any feelings of ear pressure or blockage?		
Do you find exposure to moderately loud sounds make your tinnitus worse?		
What is your current occupation?		

General Hearing Problems

	Y/N	Details/Comments
Do you have any difficulties hearing when there is background noise?		

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Do you have difficulties understanding in one-to-one conversations?		
Do you have difficulties hearing the TV?		
Do you have difficulties hearing on the telephone?		

	Y/N	Details/Comments
Do you have any dizziness or balance problems?		
Do you find external sounds unpleasant or uncomfortable?		
Do you dislike certain external sounds?		
Do you wear ear protection / ear plugs?		

Please rank the auditory problems you experience from most troublesome (1) to least troublesome (3)

	Hearing Loss
	Tinnitus
	Sensitivity to Loud Sounds

Effect of the Tinnitus	**Y/N**	**Details/Comments**
Does your tinnitus prevent you from getting to sleep at night?		

How many times per night did you awake in the last week? _____

How has tinnitus affected your work life? _____

How has tinnitus affected your home life? _____

How has tinnitus affected your social activities?

Is there anything else you would like to add that might be relevant to understanding what caused your tinnitus?

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Today's Date:_____

Full Name: _____

Detailed Trigger Inventory - Misophonia Activation

Please list all your triggers. Several triggers or sources can be listed together if they have the same ratings.

	Trigger Sound/Sight	Source (person)	Emotional Response	Physical Sensation
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				

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Part A: Emotional Response*

0	I hear a known trigger sound but feel no discomfort.
1	I am aware of the presence of a known trigger person but feel no, or minimal, anticipatory anxiety.
2	Known trigger sounds elicit minimal psychic discomfort, irritation, or annoyance. No symptoms of panic or fight or flight response.
3	I feel increasing levels of psychic discomfort but do not engage in any physical response. I may be hyper-vigilant to audio-visual stimuli.
4	I engage in a minimal physical response – non-confrontational coping behaviors, such as asking the trigger person to stop making the noise, discreetly covering one ear, or by calmly moving away from the noise. No panic or fight or flight symptoms exhibited.
5	I adopt more confrontational coping mechanisms, such as overtly covering my ears, mimicking the trigger person, make repeated sounds, or display overt irritation.
6	I experience substantial psychic discomfort. Symptoms of panic and a fight or flight response begin to engage.
7	I experience substantial psychic discomfort. Increasing use (louder, more frequent) use of confrontational coping mechanisms. I may re-imagine the trigger sound and visual cues over and over again, sometimes for weeks, months or even years after the event.
8	I experience substantial psychic discomfort and some violence thoughts.
9	Panic/rage reaction in full swing. Conscious decision not to use violence on trigger person. Actual flight from vicinity of noise and/or use of physical violence on an inanimate object. Panic, anger or severe irritation may be manifest in my demeanor.
10	Actual use of physical violence on a person or animal (i.e., a household pet). Violence may be inflicted on self (self-harming).

*MAS-1 from www.misophonia-UK.org

Part B: Physical Sensation

0	I feel no physical sensation.
1	I feel minimal physical sensation and can ignore it.
2	I feel some physical sensation but can often/always ignore it.
3	I feel some physical sensation but have difficulty or cannot ignore it.
4	I feel elevated physical sensation and usually cannot ignore it.
5	I feel elevated physical sensation, definitely cannot ignore it
6	I feel elevated physical sensation, cannot ignore it and each incidence has an impact on my life
7	I feel physical sensation as described above and cannot cope with it
8	I feel physical sensation which can be best described as emotional pain
9	I feel physical sensation which can be best described as physical pain
10	I feel physical sensation which is overpowering and is causing physical pain

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Acknowledgement

Treatment, Consent, and Billing Agreement

Health Insurance Portability & Accountability Act (HIPPA) Acknowledgement

Authorization for Treatment and Procedures: I hereby agree to and give consent to be treated by *Audiology & Hearing Services of Charlotte, PLLC.*

_____ **(initial here) HIPPA Acknowledgement:** By initialing this section and signing below, I acknowledge that I have had access to *Audiology & Hearing Services of Charlotte, PLLC*'s notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available upon request.

_____ **(initial here) Participation in Insurance Products:** By initialing this section and signing below, I relieve *Audiology & Hearing Services of Charlotte, PLLC* of any responsibility in reference to nonparticipation in the insurance or if my services were to be performed by another entity.

_____ **(initial here)Release of Information:** By initialing this section and signing below, I give permission to *Audiology & Hearing Services of Charlotte, PLLC* to disclose all or any part of my medical records to any of my other treating health care providers as needed for treatment purposes. *Audiology & Hearing Services of Charlotte, PLLC* will release information as permitted by law and/or HIPPA regulations.

_____ **(initial here) Educational and/or Marketing Information:** By initialing this section and signing below, I authorize *Audiology & Hearing Services of Charlotte, PLLC* to send me educational and/or marketing information on the products and services offered by *Audiology & Hearing Services of Charlotte, PLLC*. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ **(initial here) Financial Responsibility** By initialing this section and signing below, I agree to accept the financial policies of *Audiology & Hearing Services of Charlotte, PLLC*. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

Printed Name:_____

Signature of Patient or Guardian: _____

Date: _____

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Late Policy

Late Policy

If a patient is late for an appointment we ask that you call and let us know you are on your way.
However, if you are more than 15 minutes late you will have to reschedule your appointment and will be considered a "No-Show".

Cancellation of Appointment(s) / No-Shows

Patients wanting to cancel an appointment are asked to call the office 24 hours in advance. The charge for not canceling within a 24-hour notice is $25.00, which will be charged to your account and is not payable by any insurance company.

Patients who "No-Show" with no previous notification three times for scheduled appointments may be discharged from the practice.

Informed consent /Agreement:
□ I have been informed of and understand the Clinic's late policy.
□ I have been informed of and understand the Audiology & Hearing Services of Charlotte No Show/ Late Cancellation Policy. I understand that a no-show or late cancellation will result in a $25.00 Charge that is not covered by any insurance. I understand that three consecutive no show or late Cancellations may result in dismissal from the Clinic.

Signature of Patient / Guardian: _____ Date:_____