NYHD | INSTITUTE FOR HEARING & BALANCE

120 East 56th Street, Suite 430
New York, New York 10022
Tel. 212 774 1971
www.NewYorkTinnitusDoctors.com

**WELCOME!** Thank you for your interest in NYHD | Tinnitus and our center for tinnitus management. The center provides comprehensive diagnostic assessments, education, and management strategies for people who are bothered by their tinnitus. Our goal is to provide you with the information and tools you need to guide you to a point where your tinnitus is no longer an intrusion.

We are located at 120 East 56th Street, Suite 430 in Manhattan. Our office is between Lexington and Park Avenues, and is easily accessible by public transportation. There are also several parking garages within a block or two.

**WHAT SHOULD I EXPECT?**
Your initial consultation lasts approximately one hour. It is recommended that you bring a friend or relative to the appointment. A complete audiological evaluation and a battery of hearing tests will be performed which will provide us with information about your hearing, as well as tinnitus and/or sound sensitivity. Some of these tests are not routinely performed at other clinics. If you recently had any other audiological or medical tests, please bring those results with you. Due to the specialized nature of some of the tests performed in our center, we will need to perform our own assessment even if you have had testing completed recently.

Following your assessment, the results will be discussed with you in detail and your questions will be addressed. Based on what is found during the consultation, an individualized plan is established to guide you on the path to managing your tinnitus. This might entail techniques such as TRT (Tinnitus Retraining Therapy), hearing instruments, stress/ anxiety management, breathwork, hearing protection, enhanced sound environment, or a combination of several of these options.

**WILL MY INSURANCE COVER THE EVALUATION?**
It is possible that the diagnostic procedures may be covered by your insurance plan. The coverage will depend on the type of plan you have. Please contact our practice to determine if we accept assignment from your insurance. If we do not accept your insurance, we will be happy to provide you with the exact out of pocket cost required for the assessment.

Thank you for considering NYHD | Tinnitus. We look forward to seeing you for your scheduled appointment and to helping you live life beyond your tinnitus. In the event that you need to reschedule or cancel your appointment, kindly provide us with at least 48 hours notice so we can provide another patient with the opportunity to see us for care. Should you have any further questions, please feel free to contact our office at 212 774 1971.

In good health,
The NYHD | Tinnitus Team

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# Tinnitus History Form - Patient

**Please complete the following prior to your visit with your NYHD | Tinnitus Doctor of Audiology.*

| Patient Name: | DOB: | Date: |
|---|---|---|
| Primary Concern(s): | | |
| How or when did your problem first occur? | | |
| Have these concerns been previously evaluated? | | |
| If so, where/ when? | | |

I. Please check any of the following that you currently have or have had in the past:

- ☐ Pacemaker
- ☐ Vision Loss
- ☐ Peripheral Neuropathy
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Condition
- ☐ Measles/ Mumps
- ☐ Meningitis
- ☐ Migraines
- ☐ Ear Infections
- ☐ Meniere's Disease
- ☐ Sinusitis
- ☐ CMV
- ☐ Multiple Sclerosis
- ☐ Hearing Loss
- ☐ Head Injury/ Concussion
- ☐ HIV or AIDS
- ☐ Hepatitis
- ☐ Bell's Palsy
- ☐ Parkinson's Disease
- ☐ Stroke/ TIA
- ☐ Neurological Disorders
- ☐ Ear Trauma
- ☐ Ear Surgery
- ☐ Tingling/ Numbness in face
- ☐ MRI or CT scan of head
- ☐ Other

II. Do you have any of the following symptoms?

| | | | |
|---|---|---|---|
| ☐ Difficulty Hearing | ☐ Left Ear | ☐ Right Ear | ☐ Both |
| ☐ Ear Pain | ☐ Left Ear | ☐ Right Ear | ☐ Both |
| ☐ Ear Drainage | ☐ Left Ear | ☐ Right Ear | ☐ Both |
| ☐ Ear Fullness/ Pressure | ☐ Left Ear | ☐ Right Ear | ☐ Both |
| ☐ Tinnitus | ☐ Left Ear | ☐ Right Ear | ☐ Both |
| ☐ Dizziness | | | |
| ☐ Jaw Pain | | | |
| ☐ Recent Dental Work | | | |

III. Please mark all that apply if you have difficulty hearing.

- ☐ Difficulty in quiet environments
- ☐ Difficulty in noisy environments
- ☐ Trouble understanding television
- ☐ Trouble understanding on the telephone
- ☐ Hearing loss began suddenly
- ☐ Hearing loss progressed gradually
- ☐ Fluctuations in your hearing

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IV. Please answer the following questions if you experience tinnitus.
Did your tinnitus begin suddenly? ☐ Yes ☐ No
Did any specific incident precipitate the onset of your tinnitus? _____
Does anything make your tinnitus better? _____
Does anything make your tinnitus worse? _____

V. Please answer the following questions if you have dizziness, vertigo or imbalance.
Do you have dizziness/ vertigo? ☐ Yes ☐ No
Does anything trigger your dizziness/ vertigo? _____
Is your dizziness/ vertigo constant? ☐ Yes ☐ No
Have you experienced falls? ☐ Yes ☐ No
Do you have a fear of falling? ☐ Yes ☐ No

VI. Do you have a history of exposure to loud noise? ☐ Yes ☐ No

VII. Please list three areas you would like to address/ improve during today's appointment.

1. _____

2. _____

3. _____

VIII. For current hearing aid users only.
Do you wear one hearing aid or two? _____ How long have you worn hearing aids? _____
Make/ Model? _____ How old are your current hearing aids? _____
How often do you wear your hearing aids? _____
What would you want to improve about your current hearing aids? _____
_____

Thank you for taking the time to provide us with this very important information about your hearing health. Please be sure to complete our general patient intake form as well as the Tinnitus Functional Index questionnaire (separate documents).

# 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*

**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*

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# The Perceived Stress Questionnaire (PSQ)

| Name | |
|---|---|
| Date | |

*For each sentence, circle the number that describes how often it applied to you during the last month.*

| | Almost | Sometimes | Often | Usually |
|---|---|---|---|---|
| 1. You feel rested | 1 | 2 | 3 | 4 |
| 2. You feel too many demands are being made on you | 1 | 2 | 3 | 4 |
| 3. You are irritable or grouchy | 1 | 2 | 3 | 4 |
| 4. You have too many things to do | 1 | 2 | 3 | 4 |
| 5. You feel lonely or isolated | 1 | 2 | 3 | 4 |
| 6. You find yourself in a situation of conflict | 1 | 2 | 3 | 4 |
| 7. You feel you're doing things you really like | 1 | 2 | 3 | 4 |
| 8. You feel tired | 1 | 2 | 3 | 4 |
| 9. You fear you may not manage to attain your goals | 1 | 2 | 3 | 4 |
| 10. You feel calm | 1 | 2 | 3 | 4 |
| 11. You have too many decisions to make | 1 | 2 | 3 | 4 |
| 12. You feel frustrated | 1 | 2 | 3 | 4 |
| 13. You are full of energy | 1 | 2 | 3 | 4 |
| 14. You feel tense | 1 | 2 | 3 | 4 |
| 15. Your problems seem to be piling up | 1 | 2 | 3 | 4 |
| 16. You feel you're in a hurry | 1 | 2 | 3 | 4 |
| 17. You feel safe and protected | 1 | 2 | 3 | 4 |
| 18. You have many worries | 1 | 2 | 3 | 4 |
| 19. You are under pressure from other people | 1 | 2 | 3 | 4 |
| 20. You feel discouraged | 1 | 2 | 3 | 4 |
| 21. You enjoy yourself | 1 | 2 | 3 | 4 |
| 22. You are afraid for the future | 1 | 2 | 3 | 4 |
| 23. You feel you are doing things because you have to not because you want to | 1 | 2 | 3 | 4 |
| 24. You feel criticized or judged | 1 | 2 | 3 | 4 |
| 25. You are lighthearted | 1 | 2 | 3 | 4 |
| 26. You feel mentally exhausted | 1 | 2 | 3 | 4 |
| 27. You have trouble relaxing | 1 | 2 | 3 | 4 |
| 28. You feel loaded down with responsibility | 1 | 2 | 3 | 4 |
| 29. You have enough time for yourself | 1 | 2 | 3 | 4 |
| 30. You may feel under pressure from deadlines | 1 | 2 | 3 | 4 |
| Column Totals | | | | |

PSQ Index = (total score ___ - 30) / 90 = ___