Date: _______________

Profile

Name: ____ Date of Birth: _________________

Address: ______________________________________ City: ___________________ Zip: __________

Preferred contact phone number: _________________________________ home/cell/work (please circle)

Alternative phone number: ______________________________________ home/cell/work (please circle)

Email address: ____

I would like to receive email notifications_____ Please do not send me email notifications _____

HOW DO YOU PREFER TO BE CONTACTED (please circle): Telephone Email

Employment Status (please circle): Full-time Part-Time Retired Unemployed Student

Employer: ____

Position: ____

Marital status (please circle): Single Married Widowed

Name of spouse: ______________________

Emergency contact name: __________________________________

Emergency contact phone: ________________________________

Relationship to patient: _______________________________

Primary care physician: ________________________________

Clinic name: ____________________________________ Clinic location: ___________________________

Primary Insurance Information (please provide your insurance cards)

Insurance Company: ____

Group Number: ________________________

Member ID Number: ____

Policy Holder's Name (if different from patient):____

Policy Holder's Date of Birth: ______________________________

Policy Holder's Employer: _____________________________________

Secondary Insurance Information

Insurance Company: ____

Group Number: ________________________

Member ID Number: ____

Policy Holder's Name (if different from patient):____

Policy Holder's Date of Birth: ______________________________

Policy Holder's Employer: _____________________________________

The above information is true and accurate to the best of my knowledge

_______________________________________ ___________________________

Signature of Patient/Guardian Date

Comprehensive Case History

Patient's Name: ____ Date: ______________________

Date of Birth: ________________ Gender: Male Female Primary Language: _________________

Race: White African American Asian American Indian Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Current Employment: Full-time Part-time Retired Unemployed Stay at Home Parent Student

Current Employer: _______________________________ Position: _________________________

Do you currently use recreational drugs? Yes No

If yes, what drugs: _____________________________ How often? _______________________

Do you currently use tobacco? Yes No

If yes, what do you smoke: Cigarettes Cigars Pipe Smokeless Other:_______________

If yes, amount per day: ____

Do you currently drink alcoholic beverages? Yes No

If yes, how often: Daily Weekly Monthly Occasionally Rarely

Audiological History

Do you experience hearing loss? Yes No If so, which ear? Left Right Both

If you experience hearing loss, which best describes it? Gradual Fluctuating Sudden

When did you first notice your hearing loss? ____

What do you think is the cause of your hearing loss? _____________________________________

Have you ever had a hearing test? Yes No If so, when? _______________________________

Which ear do you use to talk on the phone? Right Left Both Have you ever worn or tried a hearing aid? Right Left Both

What type and/or style of hearing aid/s: ____

Please describe your experience:

____

____

____

Do you experience any of the following issues with your current hearing aid/s (please check all that apply):

- ☐ Some sounds are too loud
- ☐ Sounds are too soft
- ☐ Pain/Discomfort
- ☐ Sounds are tinny or metallic
- ☐ Cleaning hearing aid/s
- ☐ Naturalness of sound
- ☐ Trouble understanding in quiet
- ☐ Wind noise
- ☐ Trouble using telephone
- ☐ Feedback or whistling
- ☐ Changing batteries
- ☐ Repair issues
- ☐ Trouble understanding in noise
- ☐ Appearance of aid/s
- ☐ Sound of own voice
- ☐ Cannot tell direction of sound
- ☐ Battery life
- ☐ Other: _____________________

Please check all medical conditions that apply:

	Condition	
____	Developmental Disorders/Delay	If yes, please explain: ______________________________
____	Dizziness or Unsteadiness	If yes, accompanied by: Vomiting Nausea Ear Noises
____	Ear Deformity	If yes: Left Right Both
____	Ear Pain	If yes: Left Right Both
____	Family History of Hearing Loss	If yes, who? ______________________________________
____	History of Ear Infections	If yes: Left Right Both When? _______________
____	History of Ear Wax Buildup	If yes: Left Right Both
____	History of Noise Exposure	If yes, please explain: ______________________________
____	Previous Ear Surgery	If yes: Left Right Both
____	Tinnitus/Ringing/Noises in ears	If yes: Left Right Both Frequency? ___________
____	Other	Please explain: ___________________________________

Please answer the following questions:

Does a hearing problem cause you to feel embarrassed when meeting new people?
Yes Sometimes No

Does a hearing problem cause you to feel frustrated when talking to family or friends?
Yes Sometimes No

Do you have difficulty when someone speaks in a whisper?
Yes Sometimes No

Do you feel handicapped by a hearing problem?
Yes Sometimes No

Does a hearing problem cause you difficulty when visiting friends or family?
Yes Sometimes No

Does a hearing problem cause you to attend religious services less often than you would like?

Yes Sometimes No

Does a hearing problem cause you to have arguments with family members?
Yes Sometimes No

Does a hearing problem cause you difficulty when listening to TV or radio?
Yes Sometimes No

Does a hearing problem limit or hamper your personal or social life?
Yes Sometimes No

Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?
Yes Sometimes No

Medical History

Any illnesses, surgeries, injuries or hospitalizations since birth and their date/s of occurrence:
____
____
____

Allergies (food, medication, plastics, etc.): ____

Have you experienced any of the following major medical conditions (please check all that apply):

___ AIDS/HIV	___ Diphtheria	___ High Blood Pressure	___ Mumps
___ Appetite Change	___ Encephalitis	___ High Fevers	___ Scarlet Fever
___ Arthritis	___ Fatigue	___ Influenza	___ Stroke
___ Blood Disorders	___ Genetic Disorders	___ Malaise	___ Tonsillitis
___ Cancer	___ Headaches	___ Malaria	___ Typhoid
___ Chicken Pox	___ Head Injury	___ Measles	___ Vascular Problems
___ Diabetes	___ Heart Problems	___ Meningitis	___ Other: __________

Current Medications: **Please provide a separate list including name, amount taken, and frequency.**

Have you been immunized: Yes No

If yes, for what illnesses or diseases: ____

Please check all medical symptoms that apply:

Eye Problems (blurred vision, pain, etc): Yes No

Nose, Throat or Mouth Problems (trouble swallowing, nose bleeds, dental issues, pain, etc.): Yes No

Cardiovascular Symptoms (hypertension, chest pain, swelling, palpitations, etc.): Yes No

Respiratory Symptoms (shortness of breath, coughing, wheezing, etc.): Yes No

Gastrointestinal Issues (nausea, vomiting, weight changes, diarrhea, pain, etc.): Yes No

Musculoskeletal Symptoms (joint pain, swelling, recent trauma, etc.): Yes No

Neurologic Symptoms (numbness, headaches, seizures, muscle weakness, etc.): Yes No

Psychiatric Issues (depression, anxiety, compulsions, etc.): Yes No

Endocrine Symptoms (frequent urination, hot flashes, etc.): Yes No

Hematologic/Lymphatic Symptoms (bleeding gums, bruising, swollen glands, etc.): Yes No Allergic/

Immunologic Symptoms (hives, asthma, itching, immune deficiency, etc.): Yes No

Comments Related to Review of Symptoms:

Acknowledgement of Receipt of Notice of Privacy Practices

Name: ____

☐ By checking this box and signing below, I acknowledge that I received a copy of Hearing Health Clinic'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 posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

Signed: ____________________________________ Date: ________________

Assignment of Benefits

I hereby authorize payment of medical benefits to Hearing Health Clinic for services rendered.

Signed: ____________________________________ Date: ________________

Agreement

In consideration of services provided, I am agreeing to pay for all charged services provided to the above named patient. I agree to pay all charges not covered by insurance or Medicare.

Signed: ____________________________________ Date: ________________

Power of Attorney

The follow person listed below has been appointed my power of attorney.

Name: ____

☐ Proof of Power of Attorney provided

Signed: ____________________________________ Date: ________________

Hearing Goals Questionnaire

Name: ____ Date: __________________

Our goal is to maximize your ability to hear so that you can more easily communicate with others. In order to reach this goal, it is important that we understand your communication needs, your personal preferences, and your expectations. By having a better understanding of your needs, we can use our expertise to recommend hearing devices that are most appropriate for you.
By working together, we will find the best solution for you.

Please complete the following questions. Be as honest as possible. Be as precise as possible.

1. Please list the top three situations where you would most like to hear well. Be as specific as possible.
____
____
____

2. How important is it for you to hear well? Mark an X on the line.
Not Important____ Very Important

3. How motivated are you to wear and use hearing devices? Mark an X on the line.
Not Motivated ____ Very Motivated

4. How well do you think hearing devices will improve your hearing? Mark an X on the line.
No Improvement ___________________________________ Greatly Improve My Hearing

5. What is your most important consideration regarding hearing devices? Rank the order of each of the following factors with 1 as the most important and 4 as the least important.

____ Hearing device size and the ability of others not to see the hearing devices

____ Improved ability to hear and understand speech

____ Improved ability to understand in noisy situations (e.g., restaurants, parties)

____ Cost of the hearing devices

COMMUNICATION CONFIDENCE PROFILE

Answer each question on a scale of 5 to 1, where 1 = Extremely; 2 = Very; 3 = Moderately; 4 = Slightly; and 5= Not at all

1. Are you confident you can understand conversations when you are talking with one or two people in your own home? 1 2 3 4 5

2. Are you confident in your ability to understand when you are conversing with friends in a noisy environment, like a restaurant? 1 2 3 4 5

3. In order to hear better, how likely are you to do things like moving closer to the person speaking to you, changing positions, moving to a quieter area, finding better lighting, etc? 1 2 3 4 5

4. If you are having trouble understanding, how likely are you to ask a person you are speaking with to alter his or her speech by slowing down, repeating, or rephrasing? 1 2 3 4 5

5. How sure are you that you are able to tell where sounds are coming from (for example, if more than one person is talking, can you identify the location of the person speaking?) 1 2 3 4 5

6. Are you confident that you are able to follow quickly-paced conversational material?
1 2 3 4 5

7. Are you confident that you can focus on a conversation when other distractions are present?
1 2 3 4 5

8. Are you confident that you can understand a person speaking in large rooms like an auditorium or house of worship? 1 2 3 4 5

9. In a quiet room, are you secure in your ability to understand people with whom you are not familiar?
1 2 3 4 5

10. In a noisy environment, are you confident in your ability to understand people speaking with whom you are not familiar? 1 2 3 4 5

11. Are you confident that you can switch your attention back and forth between different talkers or sounds? 1 2 3 4 5

12. If you are having difficulty understanding a person talking, how likely are you to continue to stay engaged in the conversation? 1 2 3 4 5