

**Livingston** **HEARING AIDS** **Confidential Client Information**

**1 Patient Information**

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Social Security \_\_\_\_\_ E-mail \_\_\_\_\_  
 Marital Status:  Single  Widowed  Married Name of Spouse \_\_\_\_\_  
 Primary Insurance: \_\_\_\_\_ Plan Name \_\_\_\_\_  
 Secondary Insurance:  Yes  No Plan Name \_\_\_\_\_  
 Tertiary Insurance:  Yes  No Plan Name \_\_\_\_\_  
 How did you hear about us?  Patient Referral  Newspaper  Direct Mail  Television  Physician Referral  Yellow Pages  Website

**2 Medical History**

Name of Primary Care or Referring Physician \_\_\_\_\_  
 Physician's telephone number \_\_\_\_\_ Fax \_\_\_\_\_  
 Have you ever had ear surgery?  Yes  No By whom? \_\_\_\_\_  
 Have you ever had your hearing tested?  Yes  No By whom? \_\_\_\_\_  
 Is there a history of diabetes in your family?  Yes  No How many prescription drugs do you take daily? \_\_\_\_\_  
 Are you taking blood thinners?  Yes  No Do you wear a pacemaker?  Yes  No

**3 About Your Hearing**

**Do you have any of these symptoms?**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Deformity of the ears?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing loss in one ear in the last 90 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any pain in your ears?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you seen a doctor for wax removal?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sudden or rapid hearing loss in the past 90 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drainage from either ear in the past 90 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sudden or long-term dizziness?		

Which is your poorer ear?  Right  Left  Same  
 Does anyone else in your family have a hearing problem?  Yes  No Relationship to you? \_\_\_\_\_  
 In what situation does your hearing problem give you the most trouble? \_\_\_\_\_

**4 Motivation**

What motivated you to come in today? \_\_\_\_\_

**5 Hearing Aid Experience**

<input type="checkbox"/> I have a hearing aid and use it regularly in my: <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear	<input type="checkbox"/> I have inquired about hearing aids at another office(s), but did not purchase at that time.
<input type="checkbox"/> I have a hearing aid, but don't use it, or use it only occasionally.	<input type="checkbox"/> I have never used a hearing aid.
<input type="checkbox"/> I have tried a hearing aid, but returned it.	

Please complete back side →

**6 Hearing Needs Assessment**

Put a "1" before the FIRST thing that is most important to you in purchasing a hearing aid. Now put a "2" before the second most important thing to you when purchasing a hearing aid. Next, put a "3" before the third most important thing to you when purchasing a hearing aid. Lastly, put a "4" before the least important thing to you when purchasing a hearing aid. These are your choices:

\_\_\_\_\_ **Sound Quality & Clarity**    \_\_\_\_\_ **Durability/Reliability**    \_\_\_\_\_ **Cost**    \_\_\_\_\_ **Appearance**

**7 Motivation Scale**

On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

Not Motivated    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**    Very Motivated

**8 Tinnitus**

**Do you have ringing (tinnitus) in your ears?**     **No** (if "No", move to Section 9)     **Yes** (if "Yes", answer 1 - 5 below)

1. Is your tinnitus in your:     Left ear     Right ear     Both ears
2. Which option best describes the head noise you are experiencing?  
 High pitched     Low pitched     Crickets     Locust     Other: \_\_\_\_\_
3. Describe the loudness of your tinnitus?     Very loud     Loud     Moderate     Faint     Very Faint
4. Is your tinnitus:     Continuous     Intermittent
5. When did the tinnitus start? \_\_\_\_\_

**9 Self Questionnaire**

Please answer "yes," "no" or "sometimes" to each of the following items. Don't skip a question if you avoid a situation because of a hearing problem. If you wear a hearing aid(s), answer the way you hear **without** the hearing aid(s).

	Yes	No	Sometimes
1. Does your hearing problem cause you to feel frustrated when visiting with friends, relatives or neighbors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your hearing problem cause you to feel embarrassed when meeting with new people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have difficulty hearing when someone is soft spoken or speaks at a distance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your hearing problem cause you to attend social events or religious services less often than you'd like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your hearing problem cause you to become fatigued by the end of the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your hearing problem cause you difficulty when listening to TV or radio?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your hearing problem cause you difficulty when in a restaurant with relatives or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your hearing problem cause you to have arguments with family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**10 HIPAA Release & Authorization**

By checking this box and signing below, you allow Livingston Hearing Aid Center, Inc. to release all medical information to your insurance carrier(s) and for use in marketing purposes. You also agree to accept financial responsibility for all charges which are non-covered and thus not paid to Livingston Hearing Aid Center, Inc. by your insurance carrier(s) for services rendered by our office. This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in you being financially responsible for payment in full at the time of visit.

Signature of Patient or Guarantor: \_\_\_\_\_ Date: \_\_\_\_\_