RESONANCE
HEARING CLINIC
improving hearing, enhancing life

Intake Questionnaire

First Name: _____ Last Name: _____Birth Date (mm/dd/yy):____ /____ /_____

Address:_____City/town:_____Postal Code:_____

Phone: Home#_____Cell#_____Work#_____

Occupation (or Previous if retired):_____Email_____

Physician's Name:_____Physicians Town/City: _____

How did you hear about Resonance Hearing Clinic? _____

☐ **Patient Privacy Protection:** I understand the personal information gathered on this form and in subsequent testing will be kept confidential and used for treatment of my hearing health. Clinical information may be shared with agencies and individuals listed below, the referral source, physicians, individuals, and manufacturers.

☐ **Consent for treatment:** I understand that my hearing health care (e.g. assessments, hearing aid fittings, taking of impressions as needed and cerumen management as needed) will be provided by or under the direct supervision of an Audiologist and/or Hearing Instrument Practitioner who is a registered member of, and who adheres to the regulations and professional guidelines of the College of Speech and Hearing Health Professionals of BC (CSHHPBC).

☐ **Consent for email:** We will only email you appointment reminders if requested, a quick survey and/or newsletters.

Patient Signature: _____

Please list who should receive a copy of your hearing test results: _____

What hobbies or activities do you participate? _____

Who is most concerned about your hearing? ☐ Yourself ☐ Spouse ☐ Family ☐ Friends

When did you first notice a hearing problem? _____Has it become worse recently?_____

Do you hear better in your: ☐ right ear ☐ left ear ☐ both ears same

Have you been exposed to loud noise? ☐ Yes ☐ No

Do you have armed forces experience? ☐ Yes ☐ No

Have you been exposed to noise at work? ☐ Yes ☐ No

Do you have a noise induced hearing loss claim? i.e WorkSafeBC or DVA? Claim#: _____

Do you have any noises in your ears (e.g., ringing, hissing)? Please describe: _____

What serious illnesses have you had? _____

What medications are you taking? _____

Any allergies? E.g. environmental, food, medical material? _____

Do you experience:

- ☐ Pain in your ears?
- ☐ Dizziness?
- ☐ Unsteadiness?

Have you had any of the following:

- ☐ Ear infections?
- ☐ Discharge from your ears?
- ☐ Ear surgery?

Is there a family history of hearing loss that you are aware of?
If so, which members of your family? _____

When you consider getting your hearing tested, or the possibility of getting hearing aids, is there anything that causes you concern?

_____

Have you had other hearing tests? _____

How satisfied are you with your hearing?

On a scale of 1 -10, 1 being the worst and 10 being the best, how would you rate your overall hearing ability?

1 2 3 4 5 6 7 8 9 10

How satisfied are you with your ability to hear in the following situations?

	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
Quiet conversations	☐	☐	☐	☐	☐
Social events	☐	☐	☐	☐	☐
TV	☐	☐	☐	☐	☐
Children's voices	☐	☐	☐	☐	☐
Phone	☐	☐	☐	☐	☐
Games (e.g. cards)	☐	☐	☐	☐	☐
Activities (e.g. walking)	☐	☐	☐	☐	☐
Car	☐	☐	☐	☐	☐
Restaurants	☐	☐	☐	☐	☐
Meetings	☐	☐	☐	☐	☐
Music	☐	☐	☐	☐	☐