



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## Tinnitus Intake Questionnaire

### Tinnitus Characterization

If you hear more than one sound or a different sound in ear, please answer the following questions with regard to the one most annoying sound:

1. Is your tinnitus present:

- Constantly  
 Intermittently

If intermittent, how long does the tinnitus last for? \_\_\_\_\_

2. Where is your tinnitus located? (Please choose only ONE answer).

- |   |   |
|---|---|
| <input type="checkbox"/> Left ear only                        | <input type="checkbox"/> Middle of the head                 |
| <input type="checkbox"/> Right ear only                       | <input type="checkbox"/> In the head but no exact place     |
| <input type="checkbox"/> Both ears equally                    | <input type="checkbox"/> More on the right side of the head |
| <input type="checkbox"/> Both ears but worse in left ear      | <input type="checkbox"/> More on the left side of the head  |
| <input type="checkbox"/> Both ears but worse in the right ear | <input type="checkbox"/> Outside of the head                |

3. What does the tinnitus sound like? \_\_\_\_\_

4. Does the tinnitus fluctuate in pitch or intensity? (check all that apply)

- It fluctuates in pitch  
 It fluctuates in intensity  
 It does not fluctuate

5. Is the tinnitus pulsatile?

- No  
 Yes

### Tinnitus History

6. When did you first become aware of the tinnitus? \_\_\_\_\_

7. Was the onset sudden or gradual?

- Sudden  
 Gradual

Please explain: \_\_\_\_\_

8. What do you consider to have started the tinnitus? \_\_\_\_\_

9. When did the tinnitus first become disturbing to you? \_\_\_\_\_

10. Has the volume or pitch of the tinnitus changed over time?

- No  
 Yes

Please explain: \_\_\_\_\_

11. What, if anything, have you found makes your tinnitus worse? \_\_\_\_\_

12. What, if anything, have you found makes your tinnitus better? \_\_\_\_\_

13. Do you have TMJ, jaw pain, or grinding or clicking sensations in the jaw?

- No  
 Yes

14. Who have you consulted regarding your tinnitus? \_\_\_\_\_

15. What, if anything, have previous professionals said your tinnitus is due to? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## Tinnitus Intake Questionnaire Continued

16. What treatments have you undergone for tinnitus?

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> TRT          | <input type="checkbox"/> Music therapy                        |
| <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Acupuncture or chiropractic medicine |
| <input type="checkbox"/> Counseling   | <input type="checkbox"/> None                                 |
| <input type="checkbox"/> Masking      | <input type="checkbox"/> Other: _____                         |

How successful did you find these treatments? \_\_\_\_\_

17. Have you discussed your tinnitus with friends or family members?

- No  
 Yes  
If so, what was their reaction? \_\_\_\_\_

### Tinnitus Reaction

18. On a scale from 0-10, what is your typical *annoyance* level of your tinnitus.  
\_\_\_\_\_ (0= Not annoying at all, 10= Extremely annoying).

19. Over the past week, what percentage of the time you were awake were you **aware** of your tinnitus?(e.g.: 100% would indicate that you were aware of your tinnitus at all times, and 25% would indicate that you were aware of your tinnitus ¼ of the time).  
\_\_\_\_\_ % (Please write a single number between 1 and 100).

20. Over the past week, what percentage of the time you were awake were you **disturbed** by your tinnitus?  
\_\_\_\_\_ % (Please write a single number between 1 and 100).

21. When are you most bothered by your tinnitus?

- |   |   |
|---|---|
| <input type="checkbox"/> When I wake up             | <input type="checkbox"/> At work                        |
| <input type="checkbox"/> When I go to bed           | <input type="checkbox"/> Social activities around noise |
| <input type="checkbox"/> When I have to concentrate | <input type="checkbox"/> Other: _____                   |

22. Does your tinnitus interfere with any of the below activities? Check all that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> Work               | <input type="checkbox"/> Sleep               |
| <input type="checkbox"/> Family             | <input type="checkbox"/> Physical activities |
| <input type="checkbox"/> Social activities  | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Leisure activities |  |

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Are you experiencing depression or anxiety?

- No  
 Yes

If so, are you currently receiving treatment for depression or anxiety? \_\_\_\_\_

If so, do you feel your tinnitus is related?

- No  
 Yes

Please explain: \_\_\_\_\_

24. Are you experiencing any suicidal thoughts or ideations?

- No  
 Yes

25. Are you currently taking any benzodiazepines or recreational drugs?

- No  
 Yes If so, what drugs/ prescriptions? \_\_\_\_\_

26. Is there anything else you would like us to know? \_\_\_\_\_  
\_\_\_\_\_

**Tinnitus Reaction Questionnaire (TRQ)**

Name \_\_\_\_\_

Date Completed: \_\_\_\_\_

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle, general well-being, etc. Some of the effects below may apply to you, some may not. Please answer **all** questions by circling the number that **best** reflects how your tinnitus has affected you **over the past week**.

	Not at all	A little of the time	Some of the time	A good deal of the time	Almost all of the time
1. My tinnitus has made me unhappy.	0	1	2	3	4
2. My tinnitus has made me feel tense.	0	1	2	3	4
3. My tinnitus has made me feel irritable.	0	1	2	3	4
4. My tinnitus has made me feel angry.	0	1	2	3	4
5. My tinnitus has led me to cry.	0	1	2	3	4
6. My tinnitus has led me to avoid quiet situations.	0	1	2	3	4
7. My tinnitus has made me feel less interested in going out.	0	1	2	3	4
8. My tinnitus has made me feel depressed.	0	1	2	3	4
9. My tinnitus has made me feel annoyed.	0	1	2	3	4
10. My tinnitus has made me feel confused.	0	1	2	3	4
11. My tinnitus has "driven me crazy".	0	1	2	3	4
12. My tinnitus has interfered with my enjoyment of life.	0	1	2	3	4
13. My tinnitus has made it hard for me to concentrate.	0	1	2	3	4
14. My tinnitus has made it hard for me to relax.	0	1	2	3	4
15. My tinnitus has made me feel distressed.	0	1	2	3	4
16. My tinnitus has made me feel helpless.	0	1	2	3	4
17. My tinnitus has made me feel frustrated with things.	0	1	2	3	4
18. My tinnitus has interfered with my ability to work.	0	1	2	3	4
19. My tinnitus has led me to despair.	0	1	2	3	4
20. My tinnitus has led me to avoid noisy situations.	0	1	2	3	4
21. My tinnitus has led me to avoid social situations.	0	1	2	3	4
22. My tinnitus has made me feel hopeless about the future.	0	1	2	3	4
23. My tinnitus has interfered with my sleep.	0	1	2	3	4
24. My tinnitus has led me to think about suicide.	0	1	2	3	4
25. My tinnitus has made me feel panicky.	0	1	2	3	4
26. My tinnitus has made me feel tormented.	0	1	2	3	4
Total					

Wilson et al. 1991

# TINNITUS HANDICAP INVENTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**INSTRUCTIONS:** The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every question. Please do not skip any questions.

1. Because of your tinnitus, is it difficult for you to concentrate?	Yes	Sometimes	No
2. Does the loudness of your tinnitus make it difficult for you to hear people?	Yes	Sometimes	No
3. Does your tinnitus make you angry?	Yes	Sometimes	No
4. Does your tinnitus make you feel confused?	Yes	Sometimes	No
5. Because of your tinnitus, do you feel desperate?	Yes	Sometimes	No
6. Do you complain a great deal about your tinnitus?	Yes	Sometimes	No
7. Because of your tinnitus, do you have trouble falling to sleep at night?	Yes	Sometimes	No
8. Do you feel as though you cannot escape your tinnitus?	Yes	Sometimes	No
9. Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies)?	Yes	Sometimes	No
10. Because of your tinnitus, do you feel frustrated?	Yes	Sometimes	No
11. Because of your tinnitus, do you feel that you have a terrible disease?	Yes	Sometimes	No
12. Does your tinnitus make it difficult for you to enjoy life?	Yes	Sometimes	No
13. Does your tinnitus interfere with your job or household responsibilities?	Yes	Sometimes	No
14. Because of your tinnitus, do you find that you are often irritable?	Yes	Sometimes	No
15. Because of your tinnitus, is it difficult for you to read?	Yes	Sometimes	No
16. Does your tinnitus make you upset?	Yes	Sometimes	No
17. Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?	Yes	Sometimes	No
18. Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes	Sometimes	No
19. Do you feel that you have no control over your tinnitus?	Yes	Sometimes	No
20. Because of your tinnitus, do you often feel tired?	Yes	Sometimes	No
21. Because of your tinnitus, do you feel depressed?	Yes	Sometimes	No
22. Does your tinnitus make you feel anxious?	Yes	Sometimes	No
23. Do you feel that you can no longer cope with your tinnitus?	Yes	Sometimes	No
24. Does your tinnitus get worse when you are under stress?	Yes	Sometimes	No
25. Does your tinnitus make you feel insecure?	Yes	Sometimes	No

## FOR CLINICIAN USE ONLY

Total Per Column				
	x4	x2	x0	
Total Score	+	+	=	