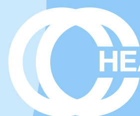
Hearing and Speech Center

# Tinnitus, Hyperacusis & Biofeedback

# WORKBOOK

Patient Name: ____________________________________________

File #: ______________________ Date ______________________



HEARING AND SPEECH CENTER

a non-profit clinic, school & community

# Tinnitus Intake Form

1. Who referred you to the Hearing and Speech Center? ______________________________

2. What is your primary reason for this appointment?

   ☐ Tinnitus ☐ Hyperacusis ☐ Biofeedback

3. How long have you had tinnitus in its present form?

   ☐ Less than a year (specify: _________ months)
   ☐ One year to two years
   ☐ Two to three years
   ☐ Three to five years
   ☐ Longer than five years (specify: ________ years)

4. When the tinnitus first became apparent to you, briefly describe what you were doing. ______________________________

   ______________________________

5. Prior to your present form of tinnitus, how long did you have tinnitus? _______________ months/years

6. Are you ever completely free of tinnitus? ☐ Yes ☐ No

   When?: ______________________________

7. Where is your tinnitus primarily located?

   ☐ The left ear
   ☐ The right ear
   ☐ Both ears equally
   ☐ Both ears but unequally
   ☐ In head

8. To the best of your understanding what is the cause of your head noise? ______________________________

   ______________________________

9. To what extent are you bothered or annoyed by your head noises?

   ☐ Extremely bothered
   ☐ Very bothered
   ☐ Slightly bothered
   ☐ Not bothered at all

10. To what extent are you disabled by your head noises? ______________________________

    ______________________________

11. Were you experiencing any kind of emotional trauma at the time when you first noticed your tinnitus? _______________

    ______________________________

12. Do your jaws seem tired? ☐ Yes ☐ No

    If so, when? ______________________________

13. Do you clench or grind your teeth? ☐ Yes ☐ No

14. Do you consider yourself to be a tense person? ☐ Yes ☐ No

15. Do you feel that emotional or physical stress worsens the tinnitus? ☐ Yes ☐ No

16. Would you say the loudness of your tinnitus is:
   - ☐ Fairly constant from day to day
   - ☐ Fluctuates widely, being very loud some days and very mild on other days
   - ☐ Usually constant but on rare occasions will decrease markedly
17. On the scale below indicate the pitch of you tinnitus. *(It might help to imagine the scale as if it were like a piano keyboard)*

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| LOW PITCH | | | | MIDDLE PITCH | | | | | HIGH PITCH |

18. On a scale of one to ten with one being soft and ten being loud, how loud is your tinnitus?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| SOFT | | | | | | | | | LOUD |

19. On a scale of one to ten with one being not annoying and ten being extremely annoying, how annoying is your tinnitus?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| NOT ANNOYING | | | | | | | | | EXTREMELY ANNOYING |

20. Check any items below which describe how your tinnitus sounds:
   - ☐ Hissing
   - ☐ Cricket-like
   - ☐ Pounding
   - ☐ Pulsating
   - ☐ Whistle
   - ☐ Ringing
   - ☐ Steam whistle
   - ☐ Bells
   - ☐ Clanging
   - ☐ Ocean roaring
21. If your tinnitus varies, what factors have you found which influence the loudness of the sound? ______________________

    ______________________________________________________________________
22. Does your tinnitus appear worse:
   - ☐ When tired
   - ☐ When relaxed
   - ☐ When tense and nervous
23. Are there changes in the sound of your tinnitus following meals? ☐ Yes ☐ No
24. Do you smoke? ☐ Yes ☐ No

    If so, how long have you smoked? _________ years

    If so, how many cigarettes per day? _________
25. Do you drink coffee? ☐ Yes ☐ No

    Do you drink alcohol? ☐ Yes ☐ No

    Do you take aspirin? ☐ Yes ☐ No
26. Have you ever received a head injury? ☐ Yes ☐ No
27. Do you now or have you ever suffered from:
   - ☐ Migraine headaches
   - ☐ Peptic ulcers
   - ☐ Heart disease
   - ☐ Hypertension (high blood pressure)
   - ☐ Depression
   - ☐ Cancer
   - ☐ Dizziness
   - ☐ Middle ear infections
   - ☐ Hyperventilation Syndrome
   - ☐ Low back pain
   - ☐ Chronic lung disease
   - ☐ Allergies (hay fever, asthma, etc.)
   - ☐ Diabetes
   - ☐ Arthritis
   - ☐ Tuberculosis
   - ☐ Other

28. How would you describe your general health? ______________________________________________

______________________________________________________________________

29. Do you have a history of ear infections? ☐ Yes ☐ No Ear surgery? ☐ Yes ☐ No

30. Have you had ear or head x-rays taken? ☐ Yes ☐ No

Results? ______________________________________________________________

31. Have you had an MRI? ☐ Yes ☐ No

Results? ______________________________________________________________

32. Do you wear ear protection in the presence of loud sounds? ☐ Yes ☐ No

33. Do you have a hearing loss? ☐ Yes ☐ No

34. Have you ever worn a hearing aid? ☐ Yes ☐ No If so, do you currently wear it? ☐ Yes ☐ No

35. If you are a hearing aid user, how does the aid affect your tinnitus? ______________________________

______________________________________________________________________

36. Does tinnitus cause you problems in getting to sleep? ☐ Yes ☐ No

37. What do you do when the tinnitus is particularly severe? _____________________________________

______________________________________________________________________

38. Have you found anything that relieves or reduces the tinnitus or head noises? _____________________

______________________________________________________________________

39. Is there any time during the day when the tinnitus is more troublesome to you? (e.g. in the morning immediately after awakening, in the evening immediately after retiring, etc.) ________________________________

______________________________________________________________________

40. Are you taking any medications? ☐ Yes ☐ No

List here: ____________________________________________________________

______________________________________________________________________

41. Have you seen any doctors regarding your hearing loss or tinnitus? If so, who? ___________________

______________________________________________________________________

42. Have you tried any of the following treatments? (Please check all that apply)

☐ Drugs
☐ Physical therapy
☐ Chiropractic
☐ Relaxation
☐ Dental
☐ Acupuncture
☐ Other ______________________________
☐ Hypnosis
☐ Nutritional/dietary modification
☐ Yoga
☐ Exercise
☐ Psychological counseling
☐ Biofeedback

43. What is your occupation? ______________________________

______________________________

44. Are you satisfied with your work? ______________________________

______________________________

45. Do you live alone? ☐ Yes ☐ No

46. What are your leisure time activities? ______________________________

______________________________

47. How would your life be different if you didn't have tinnitus? ______________________________

______________________________

48. Have you discussed your tinnitus with other friends or family members? ☐ Yes ☐ No

What was their reaction? ______________________________

______________________________

49. Do you know of others who have tinnitus? ☐ Yes ☐ No

50. Are you sensitive to loud everyday sounds? (e.g. fire engine, police siren, etc.) ☐ Yes ☐ No

51. If so, how long have you had your sensitivity to sounds? ______________________________

______________________________

52. Which started first, your sensitivity to sound or your tinnitus?

☐ Hypersensitivity first

☐ Tinnitus first

☐ Both at the same time

☐ Don't know

53. Which is more of a problem for you, tinnitus or hypersensitivity to sounds? ______________________________

______________________________

54. Are you currently pursuing any form of compensation, sickness benefit, motor vehicle accident claim or any other legal action in relation to your tinnitus? ☐ Yes ☐ No

Comments ______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

# Tinnitus Functional Index (TFI)

**Instructions:** 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% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% | ◀ 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, how much did your tinnitus interfere with... | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | |

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| A | Over the PAST WEEK, how much did your tinnitus interfere with... |
|---|---|

13. Your ability to HEAR CLEARLY?
Did not interfere ▶ 0 1 2 3 4 5 6 7 8 9 10 ◀ Completely interfered

14. Your ability to UNDERSTAND PEOPLE wo are talking?
Did not interfere ▶ 0 1 2 3 4 5 6 7 8 9 10 ◀ Completely interfered

15. Your ability to FOLLOW CONVERSATIONS in a group or at meetings?
Did not interfere ▶ 0 1 2 3 4 5 6 7 8 9 10 ◀ Completely interfered

| R | Over the PAST WEEK, how much did your tinnitus interfere with... |
|---|---|

16. Your QUIET RESTING ACTIVITIES?
Did not interfere ▶ 0 1 2 3 4 5 6 7 8 9 10 ◀ Completely interfered

17. Your ability to RELAX?
Did not interfere ▶ 0 1 2 3 4 5 6 7 8 9 10 ◀ Completely interfered

18. Your ability to enjoy PEACE AND QUIET?
Did not interfere ▶ 0 1 2 3 4 5 6 7 8 9 10 ◀ Completely interfered

| Q | Over the PAST WEEK, how much did your tinnitus interfere with... |
|---|---|

19. Your QUIET RESTING ACTIVITIES?
Did not interfere ▶ 0 1 2 3 4 5 6 7 8 9 10 ◀ Completely interfered

20. Your ability to RELAX?
Did not interfere ▶ 0 1 2 3 4 5 6 7 8 9 10 ◀ Completely interfered

21. Your ability to enjoy PEACE AND QUIET?
Did not interfere ▶ 0 1 2 3 4 5 6 7 8 9 10 ◀ Completely interfered

22. How often did your tinnitus cause you to have difficulty performing your WORK OR OTHER TASKS, such as home maintaenance, school work, or caring for children or others?
Did not interfere ▶ 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?
Did not interfere ▶ 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?
Did not interfere ▶ 0 1 2 3 4 5 6 7 8 9 10 ◀ Extremely bothered or upset

25. How DEPRESSED were you because of your tinnitus?
Did not interfere ▶ 0 1 2 3 4 5 6 7 8 9 10 ◀ Extremely depressed

# Tinnitus Severity Scale

Please read each group of statements on this questionnaire. Select the one statement in each group which best describes the way you have been feeling this week. Circle the number beside the statement.

1. I am always aware of my tinnitus.
   I am usually aware of my tinnitus.
   I am occasionally aware of my tinnitus.
   I am seldom aware of my tinnitus.
2. I believe my tinnitus always interferes with my hearing.
   I believe my tinnitus often interferes with my hearing.
   I believe my tinnitus occasionally interferes with my hearing.
   I believe my tinnitus seldom/never interferes with my hearing.
3. I am always irritable as a result of my tinnitus.
   I am often irritable as a result of my tinnitus.
   I am occasionally irritable as a result of my tinnitus.
   I am seldom/never irritable as a result of my tinnitus.
4. I am always upset when I have to take medication (sleeping pills and/or tranquilizers) because of my tinnitus.
   I am often upset when I have to take medication because of my tinnitus.
   I am occasionally upset when I have to take medication because of my tinnitus.
   I am seldom/never upset when I have to take medication because of my tinnitus.
5. I've become an extremely nervous person because of my tinnitus.
   I've always been a nervous person and the tinnitus is making me more nervous.
   I've never considered myself a nervous person but my tinnitus sometimes makes me nervous.
   My tinnitus has no effect on my nerves.
6. My hearing loss always interferes with my ability to communicate with others.
   My hearing loss often interferes with my ability to communicate with others.
   My hearing loss occasionally interferes with my ability to communicate with others.
   My hearing loss never interferes with my ability to communicate with others.
7. My tinnitus has made me change most of my relationships with others.
   My tinnitus has made me change many of my relationships with others.
   My tinnitus has made me change a few of my relationships with others.
   My tinnitus has had no effect on my relationships with others.
8. I am extremely bothered by my tinnitus.
   I am very bothered by my tinnitus.
   I am slightly bothered by my tinnitus.
   I am not bothered at all by my tinnitus.

9. If my tinnitus stays the same, I am worried about my ability to function.

   If my tinnitus becomes worse, I am worried about my ability to function.

   If my tinnitus stays the same, I am not worried about my ability to function.

   I am not worried about my ability to function regardless of any change in my tinnitus.

10. Because of my tinnitus it takes me more than one hour to fall asleep and I awaken during the night and can't get back to sleep quickly.

    Because of my tinnitus it takes me more than one hour to fall asleep.

    Because of my tinnitus I awaken in the middle of the night and I can't get back to sleep quickly.

    I have no trouble sleeping.

11. My tinnitus always interferes with my ability to concentrate.

    My tinnitus usually interferes with my ability to concentrate.

    My tinnitus occasionally interferes with my ability to concentrate.

    My tinnitus does not interfere with my ability to concentrate.

12. Because of my hearing loss, I always avoid activities where groups are present.

    Because of my hearing loss, I often avoid activities where groups are present.

    Because of my hearing loss, I occasionally avoid activities where groups are present.

    Because of my hearing loss, I never avoid activities where groups are present.

13. I am always annoyed by my tinnitus regardless of how loud it is.

    I am often annoyed by my tinnitus regardless of how loud it is.

    I am only annoyed by my tinnitus when it is loud.

    I am not annoyed by my tinnitus regardless of how loud it is.

14. I always feel depressed as a result of my tinnitus.

    I usually feel depressed as a result of my tinnitus.

    I occasionally feel depressed as a result of my tinnitus.

    My tinnitus does not affect my moods.

15. Because of my tinnitus, I no longer participate in outside activities.

    Because of my tinnitus, usually avoid outside activities.

    Because of my tinnitus, I occasionally avoid outside activities.

    I never avoid outside activities because of my tinnitus

# Tinnitus Handicap Inventory (THI)

Instructions: To fill out the questionnaire, check off the box for "Yes," "No" or "Sometimes" next to each question.

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

Newman, C. W., Jacobson, G. P., & Spitzer, J. B. (1996). Development of the Tinnitus Handicap Inventory. Arch Otolaryngol Head Neck Surg, 122 , 143-148.

McCombe, A., Bagueley, D., Coles, R., McKenna, L., McKinney, C. & Windle-Taylor, P. (2001). Guidelines for the grading of tinnitus severity: The results of a working group commissioned by the British Association of Otolaryngologists, Head and Neck Surgeons, 1999. Clin Otolaryngol, 26 , 388-393.

# Tinnitus Reaction Questionnaire TRQ

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 all 1991

# Decreased Sound Tolerance (Hyperacusis) Questionnaire

1. How long have you had your hyperacusis (decreased sound tolerance)? ______________________________

   ______________________________________________________________________

2. Do you associate the onset of your hyperacusis (decreased sound tolerance) with a specific event? ☐ Yes ☐ No

   If YES, please explain:

3. In which ear is the sensitivity to sound a problem for you?

   __________ Right ear only __________ Left ear only _________ Both ears

4. Does your hyperacusis (decreased sound tolerance) vary? ☐ Yes ☐ No

   If YES, under what circumstances does it vary? ______________________________

   ______________________________________________________________________

5. Please list the type(s) of sounds that are bothersome to you: ______________________________

   ______________________________________________________________________

6. Are you sensitive to other sensory stimuli? (ex: light, touch, etc.) ☐ Yes ☐ No

   If YES, please explain: ______________________________

   ______________________________________________________________________

7. Are you taking any medication? ☐ Yes ☐ No

   If YES, please list: ______________________________

   ______________________________________________________________________

8. Do you also have tinnitus? (e.g., ringing or other noises in the ear(s)/head) ☐ Yes ☐ No

9. Has your hyperacusis (decreased sound tolerance) affected your relationship with others? ☐ Yes ☐ No

10. Has your hyperacusis (decreased sound tolerance) caused you to change jobs or employment settings? ☐ Yes ☐ No

11. Has your hyperacusis (decreased sound tolerance) affected your social activities? ☐ Yes ☐ No

12. Does your hyperacusis (decreased sound tolerance) interfere with your sleep? ☐ Yes ☐ No

13. Do you use ear protection? ☐ Yes ☐ No

    If YES, what type of ear protection? ______________________________

    If YES, when did you start using ear protection? ______________________________

    If YES, how often do you use ear protection? ______________________________

14. Do you have a hearing loss? ☐ Yes ☐ No

15. Have you seen a doctor or other health professional regarding this condition? ☐ Yes ☐ No

    If YES, please list the professional(s): ______________________________

    ______________________________________________________________________

# MODIFIED Khalfa Hyperacusis Questionnaire (Khalfa et al,2002)

| | | | |
|---|---|---|---|
| I. Do you have trouble concentrating in a noisy or loud environment? | Yes | Sometimes | No |
| 2. Do you have trouble reading in a noisy or loud environment? | Yes | Sometimes | No |
| 3. Do you ever use earplugs or earmuffs to reduce your noise perception? (Do not consider the use of hearing protection during abnormally high exposure situations.) | Yes | Sometimes | No |
| 4. Do you find it harder to ignore sounds around you in everyday situations? | Yes | Sometimes | No |
| 5. Do you find it difficult to listen to speaker announcements (such as airports, air planes, trains, etc.)? | Yes | Sometimes | No |
| 6. Are you particularly sensitive to or bothered by street noise? | Yes | Sometimes | No |
| 7. Do you automatically cover your ears in the presence of somewhat louder sounds? | Yes | Sometimes | No |
| Subscale Total ________________ | | | |
| 8. When someone suggests doing something (going out to the cinema, a concert, etc.), do you immediately think about the noise you are going to have to put up with? | Yes | Sometimes | No |
| 9. Do you ever turn down an invitation or not go out because of the noise you would have to face? | Yes | Sometimes | No |
| 10. Do you find the noise unpleasant in certain social situations (e.g., nightclubs, pubs or bars, concerts, firework displays, cocktail receptions)? | Yes | Sometimes | No |
| 11. Has anyone you know ever told you that you tolerate noise or certain kinds of sounds badly? | Yes | Sometimes | No |
| 12. Are you particularly bothered by sounds others do not find bothersome? | Yes | Sometimes | No |
| 13. Are you afraid of sounds that others do not fear? | Yes | Sometimes | No |
| Subscale Total ________________ | | | |
| 14. Do noise and certain sounds cause you stress and irritation? | Yes | Sometimes | No |
| 15. Are you less able to concentrate in noise toward the end of the day? | Yes | Sometimes | No |
| 16. Do stress and tiredness reduce your ability to concentrate in noise? | Yes | Sometimes | No |
| 17. Do you find sounds annoy you and not others? | Yes | Sometimes | No |
| 18. Are you emotionally drained by having to put up with all daily sounds? | Yes | Sometimes | No |
| 19. Do you find daily sounds having an emotional impact on you? | Yes | Sometimes | No |
| 20. Are you irritated by sounds that do not bother others? | Yes | Sometimes | No |
| 22. My tinnitus has made me feel hopeless about the future. | Yes | Sometimes | No |
| 23. My tinnitus has interfered with my sleep. | Yes | Sometimes | No |
| 24. My tinnitus has led me to think about suicide. | Yes | Sometimes | No |
| 25. My tinnitus has made me feel panicky. | Yes | Sometimes | No |
| 26. My tinnitus has made me feel tormented. | Yes | Sometimes | No |
| Subscale Total ________________ | | | |
| Total ________________________ | | | |

# Depression Checklist

## Biological

A. Sleep Problems

1. No sleep problems ................ ☐ 0
2. Occasional sleep problems ................ ☐ 1
3. Frequent awakenings during the night or early morning awakening
   a. 1-3 nights during last week ................ ☐ 2
   b. 4+ nights during last week ................ ☐ 3

B. Appetite Problems

1. No changes in appetite ................ ☐ 0
2. Some appetite change (up or down) but no weight gain or loss ................ ☐ 1
3. Significant appetite change (up or down) with weight gain or loss (5lbs. + or - during past month) ................ ☐ 3

C. Fatigue

1. Light or no noticeable daytime fatigue ................ ☐ 0
2. Fatigue or exhausted during the day
   a. Occasionally ................ ☐ 1
   b. 1-3 days during last week ................ ☐ 2
   c. 4+ days during last week ................ ☐ 3

D. Sex Drive

1. No change in sex drive ................ ☐ 0
2. Decreased sex drive
   a. Slight ................ ☐ 1
   b. Moderate ................ ☐ 2
   c. No sex drive ................ ☐ 3

E. Anhedonia (decreased capacity to experience joy)

1. Despite periods of sadness, am able to have moments of enjoyment or pleasure ................ ☐ 0
2. Decreased ability to enjoy life
   a. Slight ................ ☐ 1
   b. Moderate ................ ☐ 2
   c. Absolutely no joy in life ................ ☐ 3

Total Score, Biological Functioning ________________

## Emotional/Psychological Symptoms

A. Sadness and Despair
1. No pronounced sadness .......... ☐ 0
2. Occasional sadness.......... ☐ 1
3. Periods of intense sadness.......... ☐ 2
4. Intense sadness almost every day .......... ☐ 3

B. Self-Esteem
1. I feel confident and good about myself.......... ☐ 0
2. I sometimes doubt myself.......... ☐ 1
3. I often feel inadequate, inferior or lacking in self-confidence .......... ☐ 2
4. I fell completely worthless most of the time .......... ☐ 3

C. Apathy and Motivation
1. It is easy to feel motivated and enthusiastic about things .......... ☐ 0
2. I occasionally find it hard to get started on projects, work, etc. .......... ☐ 1
3. I often feel unmotivated or apathetic.......... ☐ 2
4. I t is almost impossible to get started with projects, work, etc... .......... ☐ 3

D. Negative Thinking/Pessimism
1. I think in relatively positive ways about my life and my future .......... ☐ 0
2. I occasionally feel pessimistic.......... ☐ 1
3. I often feel pessimistic.......... ☐ 2
4. The world seems extremely negative to me and the future looks hopeless.......... ☐ 3

E. Emotional Control
1. When I experience unpleasant feelings, such emotions may hurt, but I do not feel totally overwhelmed ........ ☐ 0
2. I occasionally feel overwhelmed by inner emotions.......... ☐ 1
3. I often feel extremely overwhelmed by inner feelings or I have absolutely no inner feelings .......... ☐ 3

F. Irritability and Frustration
1. I do nor experience undue irritability and frustration.......... ☐ 0
2. I occasionally feel quire irritable and frustrated.......... ☐ 1
3. I often feel quite irritable and become easily frustrated
   a. 1-3 days during last week .......... ☐ 2
   b. 4+ days during last week .......... ☐ 3

Total Score, Emotional/Psychological Symptoms ________________

**Total Score: Biological __________ Emotional _________ = _____________**

Developed by John Preston, PysD

# Beck Anxiety Inventory (For Biofeedback Patients Only)

Below is a list of common symptoms of anxiety. Please carefully read each item on the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

| | Not at all | Mildly but it didn't bother me much | Moderately - it wasn't pleasant at times | Severely – it bothered me a lot |
|---|---|---|---|---|
| Numbness or tingling | 0 | 1 | 2 | 3 |
| Feeling hot | 0 | 1 | 2 | 3 |
| Wobbliness in legs | 0 | 1 | 2 | 3 |
| Unable to relax | 0 | 1 | 2 | 3 |
| Fear of worst happening | 0 | 1 | 2 | 3 |
| Dizzy or lightheaded | 0 | 1 | 2 | 3 |
| Heart pounding/racing | 0 | 1 | 2 | 3 |
| Unsteady | 0 | 1 | 2 | 3 |
| Terrified or afraid | 0 | 1 | 2 | 3 |
| Nervous | 0 | 1 | 2 | 3 |
| Feeling of choking | 0 | 1 | 2 | 3 |
| Hands trembling | 0 | 1 | 2 | 3 |
| Shaky/unsteady | 0 | 1 | 2 | 3 |
| Fear of losing control | 0 | 1 | 2 | 3 |
| Difficulty in breathing | 0 | 1 | 2 | 3 |
| Fear of dying | 0 | 1 | 2 | 3 |
| Scared | 0 | 1 | 2 | 3 |
| Indigestion | 0 | 1 | 2 | 3 |
| Faint/lightheaded | 0 | 1 | 2 | 3 |
| Face flushed | 0 | 1 | 2 | 3 |
| Hot/cold sweats | 0 | 1 | 2 | 3 |
| **Column Sum** | | | | |

**Scoring** - Sum each column. Then add up the column totals to achieve a grand score. Write that score here ______________ .