HEARING SERVICES OF SANTA BARBARA

Intake Form

Patient Name _____ Sex ☐ M ☐ F
First MI Last

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____
Email _____ SSN _____
Date of Birth _____ Marital Status ☐ Married ☐ Single
Occupation _____ Employer _____
Emergency Contact _____ Phone _____
Relationship to Patient _____
Primary Care Physician _____

Is this your first hearing aid evaluation? ☐ Yes ☐ No
Have you been examined by an ear specialist in the last year? ☐ Yes ☐ No
Have you ever worn hearing aids? ☐ Yes ☐ No

Do you have any of the following:

Deformity of the ear	☐ Yes ☐ No
Ear drainage	☐ Yes ☐ No
Sudden hearing loss in the past 90 days	☐ Yes ☐ No
Acute or chronic dizziness	☐ Yes ☐ No
Pain or discomfort in either ear	☐ Yes ☐ No
Hearing loss in one ear only	☐ Yes ☐ No
Wax removed by a physician	☐ Yes ☐ No
Tinnitus / ringing in the ears	☐ Yes ☐ No

How did you find out about us?

☐ Yellow Pages	☐ Internet	☐ Referred by Patient _____
☐ Advertisement	☐ Insurance	☐ Referred by Physician _____
☐ Consumer Seminar	☐ Employer	☐ Other _____

☐ I acknowledge I have received the Health Insurance Portability and Accountability Act policy for this office.

☐ I have received information about the non-discrimination policy for this office.

☐ I have received information about the translation services offered by this office.

Patient Signature _____ Date _____

Does a hearing problem cause you to feel embarrassed when you meet new people?	☐ Yes ☐ No
Does a hearing problem cause you to feel frustrated when talking to members of your family?	☐ Yes ☐ No
Do you have difficulty hearing when someone speaks in a whisper?	☐ Yes ☐ No
Do you feel handicapped by a hearing problem?	☐ Yes ☐ No
Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	☐ Yes ☐ No
Does a hearing problem cause you to attend religious services less often than you would like?	☐ Yes ☐ No
Does a hearing problem cause you to have arguments with family members?	☐ Yes ☐ No
Does a hearing problem cause you difficulty when listening to TV or radio?	☐ Yes ☐ No
Do you feel that difficulty with your hearing limits or hampers your personal or social life?	☐ Yes ☐ No
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	☐ Yes ☐ No

If you answered "yes" to one or more of these questions, you could benefit from hearing devices.

THIS PORTION TO BE COMPLETED BY HEARING CARE PROFESSIONAL

☐ Quiet Conversation	☐ Home Telephone	☐ Cell Phones	☐ Outdoor Activities
☐ Door Bell	☐ Driving	☐ Shopping	☐ Entertainment Venues (Casinos, Exhibit Halls, etc.)
☐ Phone Ringing	☐ Religious Services	☐ Movie Theaters	☐ Busy Restaurants
☐ Alarms (Clock, Security, Timers, etc.)	☐ Adult Conversations	☐ Health Clubs	☐ Frequent Social Gatherings
	☐ Small Family Gatherings	☐ Small Group Meetings	☐ Smartphones
	☐ Quiet Restaurants	☐ Conversations with Children	☐ Conference Calls
		☐ Television	☐ Multimedia Connectivity (Home Theater, Computer, Phone, etc.)
		☐ Open/Reverberant Home	☐ Travel & Airports
		☐ iPod®/Personal Music Players	☐ Concerts & Arts
			☐ Group Presentations
Total _____	Total x2 _____	Total x3 _____	Total x4 _____ Grand Total _____

Desired lifestyle? ☐ Private ☐ Quiet ☐ Active ☐ Dynamic **Does the companion agree?** ☐ Yes ☐ No

What are the top three environments in which you would like to hear better?	**SCALE OF 1-4**	**PRE**	**POST**
1. _____		_____	_____
2. _____		_____	_____
3. _____		_____	_____

What is important to you in hearing device technology?

- ☐ Direct Bluetooth™ or iPhone® connection
- ☐ T-coil to connect to looped facilities
- ☐ Automatic features and simple to use
- ☐ Invisible or cosmetically appealing
- ☐ Sound therapy for tinnitus