 CLIENT INFORMATION SHEET

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name:\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preferred Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_

 First M.I. Last

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **E-Mail**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Male/Female Marital Status**: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_

**Alternate Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If retired, what type of work did you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Permission to release copy of test information to Physician? \_\_\_\_\_ Yes \_\_\_\_\_ No

**How did you hear about us?**

\_\_\_ Radio \_\_\_ Web \_\_\_ Facebook \_\_\_ YP \_\_\_ Mailer \_\_\_ TV \_\_\_ **Physician** \_\_\_ **Client**

***If Physician or Client*** – **please give us their name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY:**

Will this be your first hearing test? \_\_\_ Yes \_\_\_ No

 If no, when was your last test? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has an ear physician examined you in the last 6 months? \_\_\_ Yes \_\_\_ No

Have you ever had ear surgery? \_\_\_ Yes \_\_\_ No

Do you have a history of ear infections? \_\_\_ Yes \_\_\_ No

Do you have a history of exposure to loud noises? \_\_\_ Yes \_\_\_ No

Do you have any family history of hearing loss? \_\_\_ Yes \_\_\_ No

Do you have any of the following?

 Ear drainage \_\_\_ Yes \_\_\_ No

 Sudden or rapid hearing loss during the last 90 days \_\_\_ Yes \_\_\_ No

Acute or recurring dizziness \_\_\_ Yes \_\_\_ No

 Ear pain \_\_\_ Yes \_\_\_ No

 Ringing in the ears \_\_\_ Yes \_\_\_ No

**HEARING HISTORY SURVEY**

When you are in a crowded room, can you follow the conversation? \_\_\_ Yes \_\_\_ No

Do you often ask that statements, questions and directions be repeated? \_\_\_ Yes \_\_\_ No

Do you hear people speaking but have difficulty understanding the words? \_\_\_ Yes \_\_\_ No

Do others raise their voices or move closer to help you hear them? \_\_\_ Yes \_\_\_ No

Do you have to turn the television up louder than normal to hear clearly? \_\_\_ Yes \_\_\_ No

Do you ever have to concentrate so intently to hear that you tire from it? \_\_\_ Yes \_\_\_ No

Do you ever avoid situations because of your hearing problem? \_\_\_ Yes \_\_\_ No

Do you have difficulty understanding conversations in a motor vehicle? \_\_\_ Yes \_\_\_ No

Do you have difficulty understanding conversations on the phone? \_\_\_ Yes \_\_\_ No

Do you hear some people better than others? \_\_\_ Yes \_\_\_ No

Do you feel safe with your ability to hear sounds outside of your home? \_\_\_ Yes \_\_\_ No

Do you have particular difficulty understanding women or children? \_\_\_ Yes \_\_\_ No

In what one situation would you most like to hear and understand? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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You are here today because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you presently own hearing aids? \_\_\_ None \_\_\_Left \_\_\_ Right \_\_\_ Both

 If so: Make: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Model: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year Purchased: \_\_\_\_\_\_\_\_\_\_

If we find through the consultation that you can be helped, are you ready to move forward? \_\_\_ Yes \_\_\_ No

Would you be interested in discussing financing options for your purchase? \_\_\_ Yes \_\_\_ No