

**TINNITUS PATIENT MANAGEMENT PROGRAM**

AUDIOLOGY  
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SAN FRANCISCO, CALIFORNIA 94115-0340  
PHONE: 415-353-2101 FAX: 415-353-2883

Thank you for contacting the UCSF Audiology Division. Enclosed you will find information regarding the Tinnitus Patient Management Program at UCSF. The purpose of this program is to establish an individualized tinnitus management plan designed for your particular needs. It is our belief that tinnitus patients are best served by a comprehensive, multidisciplinary approach. Therefore, in order to ensure that all appropriate diagnostic test procedures have been completed, we request that all tinnitus patients seen in this program have been seen, or are scheduled to be seen, by an otologist. In addition, because of the psychological impact of tinnitus it is quite possible that we will recommend a consultation with a behavioral health specialist. The behavioral health specialists we commonly work with are Dr. Linda Centore, RN, Ph.D. (415-502-6301) and Dr. Jennifer Gans, Psy.D. (415-244-7711). If you need a referral to an otologist or ENT specialist, you may phone the UCSF ENT Clinic (415-353-2757).

Because it is important to determine whether your tinnitus is related to a treatable or a systemic condition, we strongly urge that you have had a recent complete physical examination including laboratory tests designed to identify vascular, renal, and autoimmune disorders, as well as radiologic studies designed to identify benign growths.

If you have not had an audiological evaluation in the past six months, please notify the receptionist when making your appointment so that sufficient time can be scheduled to include this during your appointment here.

**Included in this packet are a Tinnitus Intake Form and a Tinnitus Handicap Inventory. Please fill these out and fax or mail them, along with any audiological records, to our clinic. Once we receive your packet of completed forms, they will be reviewed and you will then be contacted to schedule an appointment.**

At your appointment, you will be educated about current theories of tinnitus, as well as treatment and management procedures, including potential advantages and limitations.

It is important to recognize that many of these management procedures are not intended to cure tinnitus. Rather, they are procedures designed to assist you to cope with tinnitus and develop strategies to best adapt to the symptom. Please be aware that the success of any tinnitus management approach depends on your interaction and active participation.

***Insurance does not cover the cost of tinnitus counseling and management. The cost for this service is approximately \$300. Follow-up counseling ranges from \$100 – \$200 per visit. Test procedures associated with the tinnitus counseling appointments, such as hearing tests and tinnitus matching, may be covered by your insurance. These are noted on the following page. It is your responsibility to obtain written authorization from your insurance company for the test procedures noted on page 2. If your insurance company does not cover any or all of these procedures, or if you have not obtained pre-authorization for each procedure, you will be expected to pay in full at the time of your appointment. These fees do not cover the cost of hearing aids, earplugs, and/or electronic sound generating devices.***

The insurance CPT codes that may be required for your first visit include:

92625            Tinnitus Matching

This test matches the loudness and pitch of the tinnitus to externally generated stimuli.

92587            Otoacoustic Emissions-Limited

These tests assess cochlear outer hair-cell function to assist in identifying location of auditory pathology.

*If you have not had a hearing test within the past six months, you may need to request authorization for the following tests, which would be conducted on an “as needed” basis:*

92557            Comprehensive Audiological Evaluation

This extensive audiological testing assesses hearing sensitivity and provides a basis for tinnitus measurements and management.

92567            Tympanometry

This test measures the pressure-compliance function of the middle-ear system to assist in ruling out middle-ear pathology.

92550            Tympanometry and Acoustic Reflex Thresholds

This testing includes both tympanometry as described above and also adds measurement of the contraction of the stapedius muscle in response to sound. It is used as part of the battery to rule out middle ear and auditory nerve dysfunction.

*Hearing aids and hearing aid exams are not paid by Medicare and are generally not covered by insurance. Hearing aids must be paid for upon receipt. If you have insurance coverage for hearing aids, our financial counselor will be happy to assist you in determining your benefits. Earplugs, earmolds, and/or electronic sound generator devices will not be billed to insurance and must be paid for at the time of service.*

**PLEASE INFORM THE RECEPTIONIST IF YOU ARE INVOLVED IN ANY LEGAL ACTION. WE MAY NOT BE ABLE TO ACCEPT YOU AS A PATIENT IN THESE CASES.**



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**TINNITUS COUNSELING APPOINTMENT AGREEMENT**

Please read the following packet of information. **You will be scheduled for a tinnitus counseling appointment once we have received and reviewed the completed paperwork, including this signed patient agreement.** You may mail/fax the paperwork to our clinic.

**After reading the attached materials, please initial each of the items below and sign at the bottom.**

**I understand that:**

\_\_\_\_\_ The purpose of the appointment is to educate me and establish an individualized tinnitus management program and is not intended to result in a cure for my tinnitus.

\_\_\_\_\_ There is no specific insurance coding for tinnitus counseling. My insurance company will not be billed, and the Audiology Clinic will not accept insurance payment for this appointment.

\_\_\_\_\_ I will pay for the appointment on the date of service. The initial appointment is typically \$300, though may be greater should other self-pay only services be necessary.

**I agree to the terms as noted above and in the Tinnitus Patient Management Program cover letter.**

\_\_\_\_\_  
**Patient Name (printed)**

\_\_\_\_\_  
**Patient Signature**

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

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Today's Date \_\_\_\_\_ Referred By \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

**When did you first experience tinnitus?**  
\_\_\_\_\_

**How long have you had tinnitus in its present form?** \_\_\_\_\_ Years \_\_\_\_\_ Months

**Briefly describe what you were doing when the tinnitus first became apparent to you.**  
\_\_\_\_\_  
\_\_\_\_\_

**Were you experiencing any kind of emotional trauma at the time when you first noticed your tinnitus?**  
\_\_\_\_\_

**What do you think is the cause of the tinnitus?**  
\_\_\_\_\_  
\_\_\_\_\_

**Where is your tinnitus primarily located?**  
 Left ear       Right ear       Both ears equally       Head  
Other (please explain): \_\_\_\_\_

**Using the scale below, indicate the loudness of:**

\_\_\_\_ Your tinnitus right now  
\_\_\_\_ Your average tinnitus  
\_\_\_\_ Your tinnitus at its worst  
\_\_\_\_ Your tinnitus at its least

0	1	2	3	4	5	6	7	8	9	10
None	Mild		Moderate			Severe		Excruciating		

**Using the scale below, indicate the pitch of your tinnitus. *It might help to imagine the scale as if it were a piano keyboard.***

0	1	2	3	4	5	6	7	8	9	10
Low pitch			Mid Pitch				High pitch			

**The loudness of your tinnitus is (check one):**

- Fairly constant from day to day
- Fluctuates widely, being very loud some days and very mild other days
- Usually constant, but occasionally decreases markedly
- Usually constant, but occasionally increases markedly

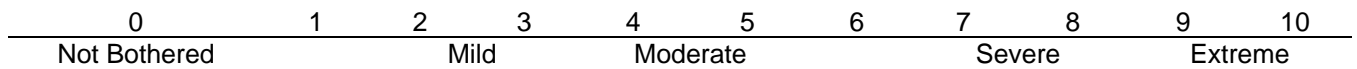
**Does your tinnitus appear worse (check all that apply):**

- When tired
- When tense or nervous
- At bedtime
- After use of alcohol
- Upon awakening
- When relaxed

**Check all items below that describe the sound of your tinnitus:**

- Hissing
- Ringing
- Cricket-like
- Whistle
- Steam whistle
- Pounding
- Pulsating
- Bells
- Clanging
- Buzzing
- Sizzling
- Clicking
- Ocean roar
- High tension wire
- Other: \_\_\_\_\_

**To what extent are you bothered or annoyed by your tinnitus?**



**When are you aware of your tinnitus?**

\_\_\_\_\_

**What percentage of the time are you bothered by your tinnitus?**

\_\_\_\_\_

**Is there a time of day when your tinnitus is most troublesome to you?**

- At work
- In morning
- In evening
- When trying to concentrate
- At social activities
- Around noise

Other: \_\_\_\_\_

**Do you consider yourself to be a tense person?**

\_\_\_\_\_

**Do you feel that emotional or physical stress worsens the tinnitus?**

\_\_\_\_\_

**How does your tinnitus interfere with your activities?:**

Concentration: \_\_\_\_\_

Work/Chores: \_\_\_\_\_

Family: \_\_\_\_\_

Religious Activities: \_\_\_\_\_

Social/Recreation: \_\_\_\_\_

Exercise: \_\_\_\_\_

Sleep: \_\_\_\_\_

Does the tinnitus prevent you from falling asleep? \_\_\_\_\_

Does the tinnitus awaken you from sleep? \_\_\_\_\_

Are you able to fall back asleep, once awakened? \_\_\_\_\_

Other: \_\_\_\_\_

**Do you have a hearing loss?**                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No

**Which is more of a problem for you, the hearing difficulty or your tinnitus?**  
\_\_\_\_\_ Hearing difficulty                    \_\_\_\_\_ Tinnitus                    \_\_\_\_\_ Not sure

**Have you been exposed to loud noise?**                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No

If so, when?

\_\_\_\_\_ Military service

\_\_\_\_\_ Work

\_\_\_\_\_ Recreation

\_\_\_\_\_ Other: \_\_\_\_\_

**Do you wear ear protection in the presence of loud sounds?**                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No

If yes, how often do you wear ear protection? \_\_\_\_\_

**Have you ever worn a hearing aid?**                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No  
If yes, do you currently wear it (them)?                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No

**If you are a hearing aid user, how does the hearing aid affect your tinnitus?**  
\_\_\_\_\_ Makes tinnitus softer                    \_\_\_\_\_ Makes tinnitus louder                    \_\_\_\_\_ No effect

**Are you adversely affected by loud sounds?**                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No  
Please explain: \_\_\_\_\_

**How would your life be different if you didn't have tinnitus?**  
\_\_\_\_\_

**Have you discussed your tinnitus with friends or family members?**                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No  
What was their reaction? \_\_\_\_\_

**Are there other family members or friends who suffer from tinnitus?**                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No

**Do you live alone?**                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No

**TREATMENT HISTORY:**

Please list all evaluations and/or treatments (including psychiatric, psychological, MRI, CT scan, etc.) you have had for your tinnitus. Please include the names of the specialists who have performed evaluations or treatments, and the approximate dates on which they were performed, using the reverse side, if necessary.

	Provider	What was done?	Date	Result
1.				
2.				
3.				
4.				
5.				

Please list any surgeries you have had (potentially related to your current symptom of tinnitus):

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Please list all medications you currently take for tinnitus:

Medication	Dose	How often?	Does it help?	Doctor

What other medications have you tried in the past for tinnitus relief?

Medication	Dose	How often?	Did it help?	Stopped (Why)?

Please list all other medications you currently take:

Medication	Dose	How often?	Purpose?	Doctor

Using the number codes below, please indicate the results of those treatments you have tried for your tinnitus. If you have not tried a given treatment, please place an "NA" in the blank for that treatment.

**1 = Major relief; 2 = Some relief; 3 = No relief; 4 = Some relief with bad side effects; 5 = Tinnitus worse; NA = Not applicable, treatment not tried**

- |   |   |
|---|---|
| <input type="checkbox"/> Surgery          | <input type="checkbox"/> Acupuncture                                |
| <input type="checkbox"/> Drug Therapy     | <input type="checkbox"/> Massage                                    |
| <input type="checkbox"/> Hearing aids     | <input type="checkbox"/> Homeopathy                                 |
| <input type="checkbox"/> Masking therapy  | <input type="checkbox"/> Biofeedback                                |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Chiropractic                               |
| <input type="checkbox"/> Antidepressants  | <input type="checkbox"/> Relaxation training or hypnosis            |
| <input type="checkbox"/> Exercise program | <input type="checkbox"/> Psychotherapy or other counseling          |
| <input type="checkbox"/> Dental           | <input type="checkbox"/> Dietary Management or nutrition counseling |
| <input type="checkbox"/> Other: _____     |   |

**Are you employed?**  Yes  No

Number of hours per week \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Are you satisfied? \_\_\_\_\_

If not employed, is your unemployment due to tinnitus? \_\_\_\_\_

**Please check all items that are applicable to you:**

- Poor health for much of your life
- History of middle ear disease
- History of Meniere's disease
- History of otosclerosis
- History of facial pain/numbness or paralysis
- History of labyrinthitis
- History of mastoiditis
- History of ear surgery
- Migraine headaches
- Hyperventilation syndrome
- Hypertension (high blood pressure)
- Cancer
- Dizziness/imbalance or vertigo
- Arthritis
- Heart disease
- Depression
- Increased use of alcohol or drugs
- Fair to poor dietary habits
- Moderate to excessive use of caffeine substances (cola, coffee, chocolate)
- Low back pain
- Whiplash or neck injury
- Tinnitus is altered by change in position
- Stiffness or reduced mobility of the neck
- Limitations and/or pain when moving head
- Significant headaches
- Headaches that change with head movement
- Tenderness/pain in the jaw area with or without chewing
- Clenching or grinding of teeth



- Limitation and/or pain with mouth opening or movement side to side
- History of clicking/locking/popping of the jaw
- Personal or family history of diabetes/alcoholism/hypoglycemia (circle)
- Personal or family history of hyperthyroid, hypothyroid or autoimmune disease
- Personal or family history of any type of hyperlipidemia
- Personal or family history of inhalant or food allergies
- History of Epstein-Barr virus, cytomegalovirus, or hepatitis (circle)
- History of excessive X-ray exposure around the head and neck
- Poor thyroid or parathyroid function
- Lyme disease

**Do you have legal action pending in relation to your tinnitus?**       Yes       No

**If not, are you planning legal action?**       Yes       No

**What is the nature of this legal action?**       Personal injury       Workers comp       Liability  
 Please explain: \_\_\_\_\_

**If you have retained an attorney in relation to your tinnitus, please indicate:**

Attorney's name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**I authorize the release of all information in my UCSF Audiology Chart to the following individuals:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# TINNITUS FUNCTIONAL INDEX

Today's Date \_\_\_\_\_  
*Month / Day / Year*

Your Name \_\_\_\_\_  
*Please Print*

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 1 2 3 4 5 6 7 8 9 10 ◀ *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*

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**.

<b>A</b>	<b>Over the PAST WEEK, how much has your tinnitus interfered with...</b>	<i>Did not interfere</i>	<i>Completely interfered</i>
		▼	▼
	13. Your ability to <b>HEAR CLEARLY</b> ?	0	10
	14. Your ability to <b>UNDERSTAND PEOPLE</b> who are talking?	0	10
	15. Your ability to <b>FOLLOW CONVERSATIONS</b> in a group or at meetings?	0	10
<b>R</b>	<b>Over the PAST WEEK, how much has your tinnitus interfered with...</b>	<i>Did not interfere</i>	<i>Completely interfered</i>
		▼	▼
	16. Your <b>QUIET RESTING ACTIVITIES</b> ?	0	10
	17. Your ability to <b>RELAX</b> ?	0	10
	18. Your ability to enjoy " <b>PEACE AND QUIET</b> "?	0	10
<b>Q</b>	<b>Over the PAST WEEK, how much has your tinnitus interfered with...</b>	<i>Did not interfere</i>	<i>Completely interfered</i>
		▼	▼
	19. Your enjoyment of <b>SOCIAL ACTIVITIES</b> ?	0	10
	20. Your <b>ENJOYMENT OF LIFE</b> ?	0	10
	21. Your <b>RELATIONSHIPS</b> with family, friends and other people?	0	10
	22. How often did your tinnitus cause you to have difficulty performing your <b>WORK OR OTHER TASKS</b> , such as home maintenance, school work, or caring for children or others? <i>Never had difficulty</i> ► 0 1 2 3 4 5 6 7 8 9 10 ◀ <i>Always had difficulty</i>	0	10
<b>E</b>	<b>Over the PAST WEEK...</b>		
	23. How <b>ANXIOUS</b> or <b>WORRIED</b> has your tinnitus made you feel? <i>Not at all anxious or worried</i> ► 0 1 2 3 4 5 6 7 8 9 10 ◀ <i>Extremely anxious or worried</i>		
	24. How <b>BOTHERED</b> or <b>UPSET</b> have you been because of your tinnitus? <i>Not at all bothered or upset</i> ► 0 1 2 3 4 5 6 7 8 9 10 ◀ <i>Extremely bothered or upset</i>		
	25. How <b>DEPRESSED</b> were you because of your tinnitus? <i>Not at all depressed</i> ► 0 1 2 3 4 5 6 7 8 9 10 ◀ <i>Extremely depressed</i>		