HARMONY™ Hearing Center

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Confidential Client Information

1 Patient Information

Name: _____ Date: _____

Address: _____ DOB: _____ Age: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status: ☐ Single ☐ Widowed ☐ Married Name of Spouse: _____

Primary Insurance: _____ Insured Name: _____ DOB: _____

Secondary Insurance: _____ Insured Name: _____ DOB: _____

How did you hear about us? ☐Patient ☐Newspaper ☐Direct Mail ☐Community Event ☐Physician Referral ☐Website

2 Medical History

Have you seen a doctor specializing in diseases of the ear?: ☐ Yes ☐ No

Please give doctor's name and date seen: _____

Name of Primary Care or Referring Physician: _____

Physician's telephone number: _____ Fax: _____

Have you ever had ear surgery: ☐ Yes ☐ No By whom: _____

Have you ever had your hearing tested: ☐ Yes ☐ No By whom: _____

Is there diabetes in your family?: ☐ Yes ☐ No How many prescription drugs do you take daily? _____

Are you taking blood thinners?: ☐ Yes ☐ No Do you wear a pacemaker?: ☐ Yes ☐ No

3 About Your Hearing

☐Yes ☐No Do you have a deformity of the ear?

☐Yes ☐No Do you have any pain in your ears?

☐Yes ☐No Sudden or rapid hearing loss in the past 90 days?

☐Yes ☐No Sudden or long-term dizziness?

☐Yes ☐No Hearing loss in one ear in the last 90 days?

☐Yes ☐No Have you seen a doctor for wax removal?

☐Yes ☐No Drainage from either ear in the past 90 days?

Which is your poorer ear?

☐Right ☐Left ☐ Same

Does anyone else in your family have a hearing problem? ☐Yes ☐No Who? _____

In what environment does your hearing problem give you the most trouble? _____

4 Hearing Aid Experience

☐ I have a hearing aid and use it regularly in my:
☐Right ear ☐Left ear

☐ I have a hearing aid, but don't use it, or use it only occasionally.

☐ I have tried a hearing aid, but returned it.

☐ I have inquired about hearing aids at another office(s), but did not purchase at that time.

☐ I have never used a hearing aid.

Please complete backside →

5 Hearing Needs Assessment

Put a "1" before the one thing that is most important to you in purchasing a hearing aid.
Now put a "2" before the second most important thing to you when purchasing a hearing aid.
Next, put a "3" before the third most important thing to you when purchasing a hearing aid.
Lastly, put a "4" before the least important thing to you when purchasing a hearing aid.
(Remember to use a 1 , 2 , 3 and a 4.)
These are your choices:

_____Sound Quality & Clarity _____ Durability/Reliability _____ Cost _____ Appearance

6 Motivation

What motivated you to come in today?_____

_____

_____

7 Motivation Scale

On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

Not Motivated . . . . . **Very Motivated**

8 Self Questionnaire

Please answer "yes, "no", or "sometimes" to each of the following items.
Do not skip a question if you avoid a situation because of a hearing problem.
If you wear a hearing aid(s), please answer the way you hear without the hearing aid(s).

	Yes	No	Sometimes
1. Does your hearing problem cause you to feel frustrated when visiting with friends, relatives or neighbors?	☐	☐	☐
2. Does your hearing problem cause you to feel embarrassed when meeting with new people?	☐	☐	☐
3. Do you have difficulty hearing when someone is soft spoken or speaks at a distance?	☐	☐	☐
4. Does your hearing problem cause you to attend social events or religious services less often than you would like?	☐	☐	☐
5. Does your hearing problem cause you to become fatigued by the end of the day?	☐	☐	☐
6. Does your hearing problem cause you difficulty when listening to TV or radio?	☐	☐	☐
7. Does your hearing problem cause you difficulty when in a restaurant with relatives or friends?	☐	☐	☐
8. Does your hearing problem cause you to have arguments with family members?	☐	☐	☐

9 Acknowledgment of Notice of Privacy Practices

☐ By checking this box and signing below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I have read, understand and I have had an opportunity to ask questions about the use and disclosure of my protected health information, and other concerns regarding my protected health information.

Signature of Patient or Guarantor: _____ Date: _____