

Tinnitus Trial Intake Questionnaire

1. Check the box next to all of the following that apply to you:

- current or prior surgically removed acoustic neuroma
- middle ear infection/active drainage from the ear and/or history of either within the previous 90 days
- impacted ear wax
- thyroid disease
- TMJ disorder
- multiple sclerosis
- infrequent or episodic tinnitus
- Pulsating tinnitus
- Prior diagnosis of central auditory processing disorder.
- Ménière's disease
- Tympanic membrane perforation or tubes.
- Prior stapedectomy
- Prior mastoidectomy
- Otosclerosis.
- Ootosyphilis.
- Labyrinthitis.
- Stapedius myoclonus syndrome.
- Cochlear implant.

2. Consistent use of any of the following drugs within the past 30 days:

- NSAIDS: high amounts of aspirin and other salicylates
- Lasix and ther "loop"diuretics
- "mycin" antibiotics such as vancomycin
- quinine and related drugs
- Chemotherapy agents such as cis-platin.
- Acute or chronic vertigo/dizziness

If you checked any of the above, you are probably not appropriate for this study. Contact us if your doctor believes you may be appropriate for this study anyway.

1. Do you have a tinnitus that is a pure tone, or is it more like a buzz, hum, static, etc?

- a) PURE TONE → Great, that is the type which is most likely to respond well.
- b) [not pure tone] → Similar treatment has been done for Pure Tone tinnitus, but not for your type. We don't know what your results will be like. If you wish, you will be allowed to participate.

2. Can you have access to a computer with a CD player for at least 45 minutes per day?

YES → Great. This is necessary.

NO → I'm sorry; that is necessary to do the trial treatment. If that changes, you may call back.

Participant Code: _____ _ DOB: ____ / ____ / ____ Today's Date ____ / ____ / ____

Participant Code: _____ (No name) Birth date _____ Sex: Male/Female

Address: _____ City: _____ State: _____ Zip: _____

Hm Phone: _____ Cell: _____ Email _____

Wk Phone: _____ Occupation: _____ Employer: _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

When did your Tinnitus first begin? (approximate year) _____ What led to it? _____

When did your Tinnitus become severe enough to seek medical help? (approximate year) _____

Time of the day do you feel least symptoms

Morning Afternoon Evening Night

Time of the day do you feel most symptoms

Morning Afternoon Evening Night

What **types of therapy have you tried** for your tinnitus (circle all)?: diet modification fasting vitamins/minerals herbs

homeopathy chiropractic acupuncture Physical Therapy Counseling conventional drugs

Hearing Aid Retraining Therapy Sound Generator (in-ear, bedside) Cochlear Implant

Massage other _____

List other current health problems **or symptoms or conditions** for which you are being treated:

Date of last physical exam _____ Practitioner name _____ MD /DC /DO Location _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? YES / NO

Recent changes in your ability to: see hear taste smell feel hot/cold sensations

move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Circle the level of **stress** you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Circle/List the major **causes of stress** (e.g., changes in job, work, residence or finances, legal problems): _____

Is your job (or previous job) associated with **potentially harmful chemicals** (e.g., pesticides, radioactivity, solvents) or health and/or **life threatening activities** (e.g., fireman, former, miner)? _____

Do you experience any of the following general symptoms **MOST DAYS?** None

Constipation

Nausea

Low grade fever

Insomnia

Diarrhea

can't control bowel movements

Disinterest in eating

Really bad fatigue

Vomiting

can't control Urination

Bleeding

Panic attacks

Headaches

Discharge

Shortness of breath

Dizziness / Vertigo

Chronic pain/inflammation

Itching/rash

Depression

Participant Code: _____ DOB: ____ / ____ / ____ Today's Date ____ / ____ / ____

Medical History (of yourself)

Past Present

- Carpal tunnel syndrome
 Dental problems
 Depression
 Diabetes
 Drug addiction
 Alcoholism
 Eating disorder
 Learning disabilities
 Mental illness
 Mental retardation
 Epilepsy
 Alzheimer's disease
 Migraine headaches
 Neurological problems
Ex.(Parkinson's, paralysis)
 Eyes, ears, nose, throat problems
 Glaucoma
 Environmental sensitivities
 Chronic fatigue syndrome
 Fibromyalgia
 Autoimmune disease
 Arthritis
 Osteoporosis
 Gout
 Cancer
 Infection, chronic
 Food intolerance
 Gastroesophageal reflux (GERD)
 Inflammatory bowel disease
 Irritable bowel syndrome
 Ulcer
 Diverticular disease
 Colitis
 Kidney or bladder disease
 Liver disease
 Gallbladder disease (stones)
 Sinus problems
 Sexually transmitted disease
 Seasonal affective disorder
 Skin problems
 Asthma
 Allergies/hay fever
 Bronchitis
 Emphysema
 Pneumonia
 Tuberculosis
 Urinary tract infection
 Cholesterol, elevated
 Heart disease
 Stroke
 Blood pressure problems
 Thyroid trouble
 Obesity
 Circulatory problems
 Varicose veins
 Genetic disorder

Other
None of the above

Medical (Men)

- Benign prostatic hyperplasia (BPH)
 Prostate cancer
 Decreased sex drive
 Infertility
 Sexually transmitted disease
 Erectile Dysfunction (<50yo=50%↑HrTA)
 Other
None of the above

Medical (Women)

- Menstrual irregularities
 Endometriosis
 Infertility
 Fibrocystic breasts
 Fibroids/ovarian cysts
 Premenstrual syndrome (PMS)
 Breast cancer
 Pelvic inflammatory disease
 Vaginal infections
 Decreased sex drive
 Sexually transmitted disease
 Other
None of the above
 Menstrual cycle Not Started yet
 Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)
Age of first period
Date of last gynecological exam
Mammogram
PAP
Form of birth control
of children
of pregnancies
 C-section
 Surgical menopause
 Natural Menopause
Date of last menstrual cycle
Length of cycle days
Days between cycles: days

Family Health History

(Parents, Sibling, relatives)

- Arthritis
 Asthma
 Alcoholism
 Alzheimer's disease
 Cancer
 Depression
 Diabetes
 Drug addiction
 Eating disorder
 Genetic disorder
 Glaucoma
 Heart disease
 Infertility
 Learning disabilities
 Mental illness
 Mental retardation
 Migraine headaches
 Neurological disorders (Parkinson's, paralysis, etc.)
 Obesity
 Osteoporosis
 Stroke
 Suicide
Other
None of the above

Health Habits

- Water: #glasses / day / wk
 Juices: #glasses / day / wk
 Other Drink : #glasses / day / wk
Alcohol:
Wine: #glasses / day / wk
Liquor: #glasses / day / wk
Beer: #glasses / day / wk
Caffeine:
Coffee: #6 oz cups/d
Tea: #6 oz cups/d
Soda w/caffeine: #cans/day
Other sources
Tobacco:
Cigarettes: #/day
Cigars: #/day

Exercise

- I do not work out
 I attend a gym
 I have home exer equipment / stab ball
 5-7 days per week
 3-4 days per week
 1-2 days per week
 45 minutes or more per workout
 30-45 minutes duration per workout
 Less than 30 minutes
 Cycle
 Walk
 Run, jog, jump rope
 Weight lift
 Swim
 Yoga
 Other

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
 Vegetarian
 Vegan
 Salt restriction
 Fat restriction
 Starch/carbohydrate restriction
 The Zone Diet
 Total calorie restriction
Specific food restrictions:
 dairy
 wheat
 eggs
 soy
 corn
 all gluten
Other

Food Frequency(average)

- (Servings(=palm-full size) per day:)
Fruits (citrus, melons, etc.)
Dark green or deep yellow/orange vegetables
Grains (unprocessed)
Processed grains(bread, cereal, etc.)
Beans, peas, legumes
Dairy
Eggs(how many)
Meat, poultry, fish

Eating Habits (you may mark several)

- Skip breakfast
 1 meal per day
 2 meals per day
 3 Meals per day
 Graze (small frequent meals)
 Food rotation
 Eat constantly whether hungry or not
 Generally eat on the run
 Add salt to food

Current Supplements

- I do not take supplements
 Multivitamin/mineral
If yes, brand
 Vitamin C / E / A
 CoQ10
 Antioxidants (e.g., lutein, etc.)
 Omega fatty acids (EPA/DHA, etc.)
 Evening Primrose/GLA
 Calcium, source
 Magnesium, Zinc
 Minerals, describe
 Friendly flora (acidophilus)
 Digestive enzymes
 Amino acids
 Herbs
 Homeopathy
 Bach flowers
 Protein shakes
 Superfoods (e.g., bee pollen, phytonutrient blends)
 Liquid meals
 Herbs - teas
Other

Sleeping Habits

hours per night, usually

Medications

(List or attach list)

- 1) Name
What for
How much
For how long
2) Name
What for
How much
For how long
3) Name
What for
How much
For how long
4) Name
What for
How much
For how long
5) Name
What for
How much
For how long

Surgeries and Injuries

(List or attach list)

- 1) Describe
When
2) Describe
When
3) Describe
When

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