Center for Hearing and Communication
Connect to Life™

50 Broadway, 6th Floor
New York, NY 10004
(917)305-7700, (Voice)
(917)-305-7999 (TTY)
(917)305-7888 (Fax)

2900 W. Cypress Creek Rd.
Ft. Lauderdale, FL 33309
(954) 601-1930 (Voice)
(954) 601-1399 (Fax)

ADULT INTAKE FORM

Today's Date: _____

Please fill in accordingly, circle or check where appropriate.

IDENTIFYING INFORMATION

1. Name (First) (Last)
2. Address
3. City, State, Zip
4. Home Phone: _____ Work Phone: _____
   Cell Phone: _____ Email: _____
5. Birth Date (MM/DD/YYYY)
6. Referred By
7. Have you been to CHC before? Yes No If yes, when?
8. Employed? Yes No Job Title: _____
   Place of Employment: _____
   Address: _____
9. Retired? Yes No Former Occupation: _____
10. What is your preferred mode of communication? Speech Sign Both
    What is your preferred language if other than English? _____
11. Social Security Number
12. Are you covered by insurance which might pay for the cost of your services here? Yes No
    If yes, please tell us: (please list all):_____
    Name of Insurance Carrier: _____
    Name of Policy Holder: _____
    Number of Policy: _____
13. In case of emergency, notify:
    Name:_____ Phone ( )_____
    Address:_____ Relationship: _____

HEARING/HISTORY

1. Do you feel you have a hearing loss? Yes No
2. If yes, when was it first noticed? By whom?
3. Did the hearing loss occur suddenly? Gradually?
4. Which is your better ear? Right Left Both ears are the same
5. Does your hearing loss change or stay the same?
6. Can you relate any changes in your hearing to any of the following?

   □ Ear infections/draining ears □ Other health conditions _____

   □ Stress □ Other _____
7. Can you hear sounds but not understand the words clearly? Yes No
8. Please check any of the following situations where you have difficulty communicating:

   □ Noisy places □ Quiet places □ Movies □ Theaters

   □ Work □ Meetings □ Religious services □ Restaurants

   □ Other_____
9. If you work, are you worried that you might lose your job because of your hearing loss? Yes No
10. Do people complain that you play the radio or TV too loud? Yes No
11. Have you ever had a hearing test before? Yes No

    If yes, please list the places of any hearing test, dates and test results

    Place of Hearing Test: _____ Date: _____

    Test results: _____
12. Are you able to use the telephone with:

    □ No difficulty □ Some difficulty □ A telephone amplifier

    □ A hearing aid □ A TTY/TDD □ VCO □ CapTel phone
13. Do you use any of the following:

    □ FM system □ Infrared listening system □ Loop system

    □ Television captioning □ Other television assistive device_____

    Alerting systems for:

    □ Doorbell □ Telephone □ Smoke/carbon monoxide detector □ Alarm clock
14. Have you taken any lip-reading/speech reading classes or auditory training/listening training? Yes No

    If yes, where? _____

HEARING AID HISTORY

- If you have NEVER worn a hearing aid, please skip questions 1-10 and continue with MEDICAL HISTORY

- If you CURRENTLY wear a hearing aid(s) please answer questions 1-8 and continue with MEDICAL HISTORY

- If you PREVIOUSLY wore hearing aid(s) but do not use amplification at this time, please answer questions 9 and 10 and continue with MEDICAL HISTORY

1. On which ear do you wear the aid? Right Left Both
2. Are you satisfied with your present aid? Yes No
3. How old is your present hearing aid?
4. Do you wear the aid every day? Yes No
5. How many hours a day do you wear your aid?
6. When did you get your first hearing aid?
7. How many hearing aids do you have?
8. Indicate any problems you have with your current hearing aid. (check all that apply)

   □ Inserting earmold/aid □ Earmold painful □ Feedback

   □ Too loud □ Sound quality unpleasant □ Too difficult to change batteries

   □ Not helpful in quiet □ Not helpful in noise □ Not helpful on the telephone

   □ Too big (visible) □ Causes too much squealing (whistling)

   □ Other (Please give a brief description): _____

   _____

   _____

If you do not have a hearing aid at this time but used one in the past, please answer the following questions:

9. How long ago did you stop using it?
10. Why did you stop using your hearing aids? (check all that apply)

    □ Could not insert earmold/aid □ Earmold was painful □ Too loud

    □ Sound quality unpleasant □ Feedback present □ Difficulty with volume control

    □ Did not help in noisy situations □ Did not feel I needed it

    □ Other (Please give a brief description): _____

    _____

    _____

MEDICAL HISTORY

1. Have you been seen by an ear doctor (otologist)? Yes No
2. If yes, print name and address of the otologist:

   _____

   _____
3. Did the doctor recommend a hearing aid? Medication? Operation?
4. Have you had earaches or ear discharge? Yes No
5. Do you experience popping, fullness or itching of the ears? Yes No
6. Do you have noises (rushing, ringing, buzzing) in your ears or head? Yes No
7. Do you ever get dizzy or lose your balance? Yes No
8. Have you ever been exposed to any of the following noises? (check all that apply)

   □ Gunfire □ Firecrackers □ Loud machinery

   □ Loud music □ Other loud noises_____
9. List the relationship, age of onset, and cause, if known, of any blood relatives known to have had an ear or hearing problem:

   Relationship Age at onset Cause

   Relationship Age at onset Cause
10. Do you consider your health: Good Fair Poor
11. List drugs taken regularly including aspirin:

    _____
12. Other health problems, please describe:

    _____
13. Have you been seen by a: Neurologist Psychiatrist
14. When was your last eye examination?
15. Do you wear glasses? Always Sometimes Never
16. Is your corrected vision: Good Fair Poor
17. Would you like more information about:

    □ Speechreading/lipreading
    □ Audiotherapy (auditory training)
    □ Assistive devices
    □ Help on the job
    □ Emotional Health and Wellness Services
    □ Center for Hearing and Communication (CHC) news, workshops and events (e-newsletter)
    □ Volunteer opportunities

HEARING HANDICAP INVENTORY (A&E Versions)

Name/ID: _____ Age: _____

INSTRUCTIONS: The purpose of this questionnaire is to identify the problems your hearing loss may be causing you. Circle ***Yes***, ***Sometimes***, or ***No,*** for each question. **DO NOT SKIP A QUESTION IF YOU AVOID A SITUATION BECAUSE OF A HEARING PROBLEM**.

E-1	Does your hearing problem cause you to feel embarrassed when meeting new people?	Yes	Sometimes	No
E-2	Does a hearing problem cause you to feel frustrated when talking to members of your family?	Yes	Sometimes	No
S-3	Does a hearing problem cause you difficulty understanding co-workers, clients, or customers?	Yes	Sometimes	No
E-4	Do you feel handicapped by a hearing problem?	Yes	Sometimes	No
S-5	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	Yes	Sometimes	No
S-6	Does a hearing problem cause you difficulty in the movie or theater?	Yes	Sometimes	No
S-7	Does a hearing problem cause you to have arguments with family members?	Yes	Sometimes	No
S-8	Does a hearing problem cause you difficulty when listening to the TV or radio?	Yes	Sometimes	No
E-9	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	Yes	Sometimes	No
S-10	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	Yes	Sometimes	No
S-11	Does a hearing problem cause you to attend religious services less often than you would like?	Yes	Sometimes	No
S-12	Do you have difficulty hearing when someone speaks in a whisper?	Yes	Sometimes	No

Score T: _____ Score E: _____ Score S: _____