

WZT INTAKE QUESTIONNAIRE

APPENDIX A THE WIDEX ZEN THERAPY INTAKE QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

Hearing Loss and tinnitus

1. How long have you had tinnitus? _____

2. What do you think caused your tinnitus?
Please, explain _____

3. Do you have a hearing loss? Yes No Not sure

If so, which is more of a problem for you, the hearing difficulty or your tinnitus?

Hearing difficulty Tinnitus Both Not sure

4. Have you been exposed to loud noise? Yes No

If so, when? Military services Work Recreation Other: _____

Have you worn ear protection when exposed to loud noise? Yes No

Please, explain _____

5. Have you ever worn a hearing aid? Yes No

6. If so, how does using a hearing aid affect your tinnitus?

Makes tinnitus softer Makes tinnitus louder No effect

If you don't wear your hearing aids, why did you stop? _____

7. Are you bothered by loud sounds? Yes No

Please, explain: _____

Tinnitus Characterization

8. Where is your tinnitus primarily located?

left ear right ear both ears equally Inside my head

9. Using the scale below, indicate the loudness of Your tinnitus in the last week

0 1 2 3 4 5 6 7 8 9 10

10. 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

11. How would you describe your tinnitus? Check all of the boxes that apply below:

- | | | | |
|-----------------------------------|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> hissing | <input type="checkbox"/> ringing | <input type="checkbox"/> cricket-like | <input type="checkbox"/> whistle |
| <input type="checkbox"/> steam | <input type="checkbox"/> whistle | <input type="checkbox"/> pounding | <input type="checkbox"/> pulsating |
| <input type="checkbox"/> clanging | <input type="checkbox"/> buzzing | <input type="checkbox"/> sizzling | <input type="checkbox"/> clicking |
| <input type="checkbox"/> bells | <input type="checkbox"/> ocean roar | <input type="checkbox"/> high tension wire | <input type="checkbox"/> Other: _____ |

12. Has your tinnitus loudness changed over time? Yes No

Please, explain _____

Tinnitus reaction

13. Using the scale below, please indicate how much you have been bothered by your tinnitus during the past week?

0 1 2 3 4 5 6 7 8 9 10

Please explain: _____

14. What makes your tinnitus worse?

- | | | | |
|----------------------------------|-----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stress | <input type="checkbox"/> Anxiety/nervous | <input type="checkbox"/> Loud noise |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Caffeine | <input type="checkbox"/> Nicotine | <input type="checkbox"/> Other: _____ |

15. When are you most bothered by your tinnitus?

- | | | |
|---|---|---|
| <input type="checkbox"/> when I walk up | <input type="checkbox"/> When I go to bed | <input type="checkbox"/> When I have to concentrate |
| <input type="checkbox"/> At work | <input type="checkbox"/> Social activities around noise | <input type="checkbox"/> Other: _____ |

16. Does your tinnitus interfere with any of the below activities? Check all that apply.

Work Family Social activities Leisure activities Sleep Physical Other: _____

Please, explain _____

17. Are you depressed, tense or nervous? Yes No

If so, are you currently in treatment for depression or anxiety? _____

If you are depressed or anxious, is your tinnitus related to this? Yes No

Please, explain _____

Work

18. Are you employed? Yes No

If so, what is your occupation _____

19. Does the tinnitus influence you negatively at work? Yes No

Please, explain _____

20. Have you discussed your tinnitus with friends or family members? Yes No

If so, what was their reaction? _____

Treatment history

21. Have you been examined by a doctor or other professional regarding your tinnitus? Check all the apply

Physician ENT doctor Hearing care professional Other: _____

Please, explain: _____

22. Please list all of the treatments (including psychiatric or psychological) you have undergone for your tinnitus (provide a date if possible).

Please list any surgeries you have had (that may be related to your tinnitus)?

23. Do you have any or any ear, nose or throat diseases?

24. Do you have any other comments or concerns related to your tinnitus?
