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Connect to Life™

[www.chchearing.org](http://www.chchearing.org)

**ADULT INTAKE FORM**

Today's Date: \_\_\_\_\_

Please fill in accordingly, circle or check where appropriate.

**IDENTIFYING INFORMATION**

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1. Name (First) \_\_\_\_\_ (Last) \_\_\_\_\_

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2. Address \_\_\_\_\_

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3. City, State, Zip \_\_\_\_\_

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4. Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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5. Birth Date (MM/DD/YYYY) \_\_\_\_\_

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6. Referred By \_\_\_\_\_

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7. Have you been to CHC before? Yes No If yes, when? \_\_\_\_\_

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8. Employed? Yes No Job Title: \_\_\_\_\_  
 Place of Employment: \_\_\_\_\_  
 Address: \_\_\_\_\_

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9. Retired? Yes No Former Occupation: \_\_\_\_\_

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10. What is your preferred mode of communication? Speech Sign Both  
 What is your preferred language if other than English? \_\_\_\_\_

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11. Social Security Number \_\_\_\_\_

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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: \_\_\_\_\_

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13. In case of emergency, notify:  
 Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**HEARING/HISTORY**

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1. Do you feel you have a hearing loss? Yes No

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2. If yes, when was it first noticed? By whom?

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3. Did the hearing loss occur suddenly? Gradually?

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4. Which is your better ear? Right Left Both ears are the same

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5. Does your hearing loss change or stay the same?

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6. Can you relate any changes in your hearing to any of the following?

Ear infections/draining ears       Other health conditions \_\_\_\_\_

Stress       Other \_\_\_\_\_

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7. Can you hear sounds but not understand the words clearly? Yes No

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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 \_\_\_\_\_

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9. If you work, are you worried that you might lose your job because of your hearing loss? Yes No

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10. Do people complain that you play the radio or TV too loud? Yes No

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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: \_\_\_\_\_

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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

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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

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14. Have you taken any lip-reading/speech reading classes or auditory training/listening training? Yes No

If yes, where? \_\_\_\_\_

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**HEARING AID HISTORY**

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- 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

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1. On which ear do you wear the aid? Right Left Both

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2. Are you satisfied with your present aid? Yes No

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3. How old is your present hearing aid?

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4. Do you wear the aid every day? Yes No

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5. How many hours a day do you wear your aid?

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6. When did you get your first hearing aid?

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7. How many hearing aids do you have?

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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): \_\_\_\_\_

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\_\_\_\_\_

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

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9. How long ago did you stop using it?

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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): \_\_\_\_\_

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\_\_\_\_\_

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## MEDICAL HISTORY

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1. Have you been seen by an ear doctor (otologist)? Yes No
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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
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7. Do you ever get dizzy or lose your balance? Yes No
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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) Membership
- Volunteer opportunities
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## HEARING INVENTORY SCREENING

- The purpose of this scale is to identify the difficulties your hearing loss may be causing you.
- Check YES, SOMETIMES, or NO for each question.
- Do not skip a question if you avoid a situation because of your hearing problem.
- Please answer the questions the way you ordinarily hear, that is, with or without a hearing aid.

Do you ordinarily wear a hearing aid? YES NO

	YES	SOMETIMES	NO
Does a hearing problem cause you to feel embarrassed when meeting new people?			
Does a hearing problem cause you to feel frustrated when talking to members of your family?			
Does a hearing problem cause you to use the phone less often than you would like?			
Do you feel handicapped by a hearing problem?			
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?			
Does a hearing problem cause you to attend religious services less often than you would like?			
Does a hearing problem cause you to have arguments with family members?			
Does a hearing problem cause you difficulty when listening to TV or radio?			
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			