

## Audiology Adult Intake Questionnaire

### IDENTIFYING INFORMATION

Patient full name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Email: \_\_\_\_\_

Biological Sex: Male  Female  Gender Identity: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

Phone (h): \_\_\_\_\_ (c): \_\_\_\_\_ (w): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Preferred method of communication:  Email  Cell phone/text  Home

Client primary language? \_\_\_\_\_ Race: \_\_\_\_\_

Is the patient employed? Yes No

Employment or previous employment, if retired? \_\_\_\_\_

Highest level of formal education: \_\_\_\_\_

If patient is unable to fill out the form, please fill out the following information:

Person completing this form: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

### PRIMARY CARE PHYSICIAN

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

### EMERGENCY CONTACT

#### Primary Emergency Contact

Name: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

#### Secondary Emergency Contact

Name: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

### PERMISSION FOR TEXT MESSAGES

I give permission for the Evelyn Hendren Cassat Speech Language Hearing Clinic to send me text messages for appointment reminders. I understand that message and data rates may apply, and that I may opt out by calling the clinic at 316-978-3289.

Patient Name: \_\_\_\_\_

Cell phone number: \_\_\_\_\_

Mobile phone carrier: \_\_\_\_\_

Signature: \_\_\_\_\_

**MEDICAL HISTORY**

Does the patient have a medical diagnosis?  Yes  No

If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

The following questions are designed to help us evaluate your auditory system. Please answer them as accurately and completely as possible.

1. Why did you choose to schedule this appointment?

\_\_\_\_\_  
\_\_\_\_\_

2. When did you first notice this problem?

\_\_\_\_\_

3. Has this problem been changing suddenly or gradually?

\_\_\_\_\_

4. Does it fluctuate? Please explain.

5. Which ear do you hear better out of?  Right  Left  Same in Both

6. On a scale from 1 to 10 (1 being the worst and 10 being the best), how would you rate your overall hearing ability? \_\_\_\_\_

7. Has your hearing worsened in the past 72 hours?  Yes  No

8. Has your hearing worsened in the past 90 days?  Yes  No

9. Does Hearing Loss run in your family?  Yes  No

If yes, please explain: \_\_\_\_\_

10. Have you been treated for ear infections as an adult?  Yes  No

11. Have you ever consulted an ear nose, and throat physician about your ears?  Yes  No

If yes, please explain: \_\_\_\_\_

12. Have you ever had an ear surgery?  Yes  No

If yes, please explain: \_\_\_\_\_

13. Are you aware of noises or ringing (tinnitus) in your ears or head?  Yes  No

If yes, in which ear do you hear the noise/ringing? \_\_\_\_\_

14. I notice the noise/ringing:  Occasionally  Constantly

15. The noise/ringing is:  not bothersome  somewhat bothersome  extremely bothersome

Please describe what the noise/ringing sounds like: \_\_\_\_\_

16. Do you have any pain in your ears?  Yes  No

17. Do you feel a pressure or fullness sensation in either of your ears?  Yes  No

If yes, please explain: \_\_\_\_\_

18. Have you ever been exposed to loud noises for any extended length of time?  Yes  No

If yes, what was the source of the noise?  Machinery  Music  Hunting  Target Shooting

Military  Other: \_\_\_\_\_

When exposed to noise did/do you wear ear protection?  Yes  No  Sometimes

19. Do you have problems with dizziness?  Yes  No

If yes, is your physician aware of your dizziness?  Yes  No

Please describe your dizzy symptoms: \_\_\_\_\_

20. Do you have a pace maker or defibrillator?  Yes  No

21. Have you ever been diagnosed with any of the following conditions?

Condition:	Yes	No	If yes, please explain
Diabetes			
Heart Disease			
Severe Arthritis in Hands			
Strokes			
Migraines			
Dementia/ Alzheimer's			
Parkinson's			
Head Trauma			
HIV/AIDS			
Multiple Sclerosis			
Bell's Palsy			
Macular Degeneration			
High Blood Pressure			
Cancer			
Sinus Issues			
Allergies			
Other			

22. Are you currently taking any medications? If yes, please list:

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### Hearing Aid History

1. Do you currently wear hearing aids?  Yes  No

If so, how long have you been wearing hearing aids? \_\_\_\_\_

2. How old are your current hearing aids? \_\_\_\_\_

3. Are you generally satisfied with your hearing aid?  Yes  No

If no, please explain:

### HHIE – Screening

Instructions: The purpose of this scale is to identify the problems your hearing loss may be causing you. Place a check mark below for each question. Do not skip a question if you avoid a situation because of your hearing problem. If you use a hearing aid, please answer the way you hear without the aid.

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

How did you hear about our clinic?

\_\_\_\_\_

\_\_\_\_\_

#### Office Use Only

Yes \_\_\_\_\_ x 4 = \_\_\_\_\_  
 Sometimes \_\_\_\_\_ x 2 = \_\_\_\_\_  
 No \_\_\_\_\_ x 0 = \_\_\_\_\_  
 TOTAL \_\_\_\_\_

0-8 = no difficulties  
 10 to 24 = mild to moderate  
 26 to 40 = severe

WICHITA STATE UNIVERSITY  
PATIENT/CLIENT EMAIL CONSENT FORM

**PLEASE READ CAREFULLY. THIS FORM DISCUSSES THE RISKS OF USING EMAIL TO SHARE PERSONAL HEALTH INFORMATION.**

As a patient or client of a Wichita State University Clinic, you may request that we communicate with you via unencrypted electronic mail (email). This Fact Sheet will inform you of the risks of communicating with your healthcare provider via email. Your health is important to us and we will make every effort to reasonably comply with your request to receive communications via email; however, we reserve the right to deny any request for email communications when it is determined that granting such a request would not be in your best interest.

WSU staff will make every effort to promptly respond to your requests for information via email; however, **IF YOU ARE EXPERIENCING AN EMERGENCY, YOU SHOULD NEVER RELY ON EMAIL COMMUNICATIONS AND SHOULD SEEK IMMEDIATE MEDICAL ATTENTION.**

Risks of using email to send protected health information include, but are not limited to:

- Email messages sent or received by WSU are generally not encrypted and may not be secure.
- Third parties may therefore be able to intercept, read, alter, forward or use personal health information transmitted by email, without authorization or detection by you or WSU.
- An unsecure email message may be accidentally or intentionally forwarded to unintended recipients.
- Employers and internet service providers generally have the right to inspect and review any email message transmitted, received, or stored using their systems.
- Information shared by email may be printed, copied, and stored by any recipient in multiple locations.
- Copies of email messages containing personal health information may be kept, for example on backup servers or hard drives, long after the "original" message is deleted by both the sender and the recipient.
- Documents may be forged, and identities may be stolen to take advantage of these vulnerabilities.
- Your personal health information in WSU's records may include information relating to prescriptions and medications, communicable diseases, physical impairments, chronic conditions, genetics, behavioral and mental health services, alcohol and drug abuse or addiction, billing and payments, and other information related to your medical care and condition.
- WSU is not responsible for any unauthorized access to or use of your personal health information that results from any unencrypted transmission that you authorize.

**PERMISSION TO ALLOW COMMUNICATIONS BY UNENCRYPTED EMAIL**

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into your medical record at the provider's discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means. By signing below, you agree to hold Wichita State University harmless for unauthorized use, disclosure, or access of your protection health information sent to the email address you provide.

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Signature of Patient

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Date

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Printed Name of Patient

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Email Address

## WSU SPEECH LANGUAGE HEARING CLINIC FINANCIAL POLICY

### PART 1: PATIENT INFORMATION

Fill out this form completely. Please print legibly.

Last Name:	First Name:	Middle Initial:
Date of Birth:		

### PART 2: WSU SPEECH LANGUAGE HEARING CLINIC FINANCIAL POLICIES

1. The cost of services provided by WSU Speech Language Hearing Clinic is your responsibility, whether you are covered by health insurance or not. Payment is expected at the time of service unless arrangements have been made prior to treatment. WSU Speech Language Hearing Clinic accepts cash, checks and credit cards. **Please note: checks must be imprinted with the bank name and the account holder's name.**
2. WSU Speech Language Hearing Clinic will process claims for any In Network Private Health Insurance Plans.
3. By giving WSU Speech Language Hearing Clinic your insurance information, you are authorizing WSU Speech Language Hearing Clinic to file a claim with (send a bill to) your insurance company for services rendered.
4. If you do not want WSU Speech Language Hearing Clinic to file a claim with your insurance company, you must notify WSU Speech Language Hearing Clinic at the time of your visit and pay in full any charges incurred at the time of the service.
5. Your insurance company may determine that some or all of the charges incurred at WSU Speech Language Hearing Clinic are not covered by your policy. It is your responsibility to know what your insurance covers and to ask questions prior to receiving services.
6. WSU Speech Language Hearing Clinic is not a contracting provider for and cannot bill KanCare, Medicaid, or Healthwave. If you have these types of government health benefits, you are responsible for paying all Speech Therapy and/or Audiology charges and it is your responsibility to seek reimbursement from these programs.
7. If you fail to pay any charges incurred within 6 months of services rendered, your outstanding charges will be sent to WSU Financial Services for collection. **Please note: if your account becomes past due, WSU Speech Language Hearing Clinic may discontinue providing services or goods until all past due amounts are paid.**
8. If you fail to pay any past due charges, WSU may refer your delinquent account to a third-party collection agency. You are responsible for paying the collection agency fee, together with all costs and expenses (including but not limited to reasonable attorney's fees and court costs) necessary for the collection of your delinquent account. You understand that your delinquent account may be reported to one or more of the national credit bureaus.
9. WSU Speech Language Hearing Clinic may charge late cancel and no-show fees if I do not cancel an appointment within notification times outlined on the WSU Speech Language Hearing Clinic website and/or in appointment reminder messages.

By signing below, I am agreeing that I:

1. Have read and understand the SHS Financial Policies as set forth above, and which may be amended from time to time;
2. Am financially responsible to pay for all services that I receive, whether covered by insurance or not;
3. Authorize WSU Speech Language Hearing Clinic to submit a claim (send a bill) to my health insurance company for services rendered and for consideration of payment and to release any medical or other information necessary to process the claim;
4. Authorize payment of my insurance benefits directly to Wichita State University; and
5. Authorize WSU Speech Language Hearing Clinic to file any mandatory reporting to the State of Kansas as required by state law

**PART 3: SIGNATURE**

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Patient Signature

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Date

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Parent / Guardian Signature (if patient is under 18)

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Date