Doc Side Audiology LLC

Anchored in FL to aid in all of your communication needs!

NEW PATIENT INTAKE FORM

Content reference and publishing instructions for Audiology Design

Read this first

This PDF is for REVIEW ONLY. It shows you every question the form contains, including the conditional sections that only some patients see. It is not the thing to publish.

The item to publish is the single file DocSide_New_Patient_Packet_2026.html. It is self-contained — all CSS, JavaScript, images and fonts are already inline. Upload it exactly as-is.

Why the live form cannot be a PDF

A PDF version of this form would lose the four things it was built to do. This is not a preference — the format cannot carry the behaviour.

- **It branches.** A patient who checks “tinnitus” is shown 50 additional questions. A patient who does not check it never sees that section at all, and is never asked to skip past it. A PDF shows everybody everything, which is exactly the eight-page paper packet this replaces.
- **It scores itself.** The Tinnitus Handicap Inventory, the Tinnitus Functional Index, PHQ-2, GAD-2 and several practice-built indices are calculated the moment the patient presses Done, with subscale breakdowns and severity bands. A PDF cannot calculate.
- **It splits what the patient sees from what the audiologist sees.** The patient's saved copy contains their answers. The clinician copy — scores, clinical flags, interpretation — is behind a staff PIN and never reaches the patient. A PDF has no such separation.
- **It sends itself.** The patient saves a copy, emails it to the practice, and can text a second short questionnaire to a family member, all from their own phone. A PDF is a document; it does none of this.

If a downloadable PDF is also wanted

That already exists and is separate. The live HTML form generates its own blank paper packets on demand — add ?print=core to the published URL for the standard intake, or ?print=all for everything. Those can be printed or saved as PDF by anyone, any time, and they always match the online form because they come from the same file. No second document to maintain.

Publishing checklist

Please tick these off and confirm back.

The file

- Upload DocSide_New_Patient_Packet_2026.html exactly as delivered.
- Do not minify it, do not split out the CSS or JavaScript, and do not wrap it in the site page template. It is designed to run full-screen on a phone and the site chrome will break the layout.
- Publish at a stable URL that will not change — suggested https://docsideaud.com/intake/. Patients will be texted this link directly.
- Expect replacements. When an updated file is sent, overwrite it at the same URL. Nothing else needs to change.

Security and privacy

- HTTPS only, with HTTP redirected to HTTPS.
- Add noindex, nofollow and block the path in robots.txt. This is a patient form, not a marketing page.

The one thing to be strict about

Patients type protected health information into this page. No third-party tracking of any kind may load on this URL or anywhere under that path — no Google Analytics, no Google Tag Manager, no Meta or Facebook Pixel, no LinkedIn or TikTok tags, no Hotjar or session recording, no chat widget, no A/B testing script, no ad remarketing tag.

If any of those are injected site-wide from the theme or from GTM, they must be explicitly excluded on this path.

Under HHS Office for Civil Rights guidance on online tracking technologies, an analytics or advertising tag on a page that collects patient health information is a reportable disclosure of protected health information unless that vendor has signed a Business Associate Agreement with the practice. None of them have.

Please confirm in writing once you have verified the page loads with zero third-party requests.

Please send back

- The final published URL. It is needed for a setting inside the file, so that the link a patient texts to a family member resolves correctly.
- Confirmation that no third-party tags load on that path.
- The name of any CDN, caching layer, WAF or server-side form handler placed in front of that page — a Business Associate Agreement is required with anyone who touches that traffic.

Second file, separate job

- DocSide_Misophonia_Web_Page.html is a patient education page. Publish at https://docsideaud.com/misophonia/. This one SHOULD be indexed — add it to the sitemap and link it from the tinnitus or services navigation. Normal site tracking is fine there; it collects nothing.

What every patient sees, and what is conditional

The pages that follow show the complete content of the form. Sections marked CONDITIONAL appear only when the patient ticks the matching box, and once ticked they are required. Sections not marked are shown to everyone.

Always shown — every patient

Welcome	Office selection, who is completing the form
About You	Name, date of birth, address, phone, email, contact preference, seasonal address
Your Care Team	How they heard about the practice, primary care physician, ENT
Who We May Talk To	Authorised contacts and what each may discuss, emergency contact, release to physicians
Reason for Visit	Chief complaint, symptom checklist, onset, worse ear, difficult situations, hearing aid history, medical history and cerumen precautions
What You May Be Missing	Five participation and withdrawal items, plus the one situation they most want back. Practice-owned wording, scored on the clinician copy only
Communication Partner permission	Whether a family member may be sent five short questions, and that person's details
How You're Doing	PHQ-2 and GAD-2. Administered to EVERY patient, not only tinnitus patients
Privacy & Consents	Notice of Privacy Practices acknowledgment, contact consents, cerumen consent, private-pay financial policy
Sign & Submit	Drawn or typed electronic signature

Conditional — shown only when ticked

Tinnitus	Triggered by “Ringing, buzzing, or other noise in my ear(s) or head.” Adds a full tinnitus intake, the 25-item Tinnitus Handicap Inventory and the 25-item Tinnitus Functional Index
Sound Sensitivity	Triggered by either sound-sensitivity box. Adds a trigger inventory, reaction severity, impact and onset
Balance & Dizziness	Triggered by “Dizziness, vertigo, or balance problems.” Adds symptom characterisation, falls, migraine and Ménière's screening, medication and orthostatic questions, prior workup, and daily-life impact

Separate link — never in the patient packet

Communication Partner	A spouse, adult child or close friend answers five short questions plus a free-text concern and how long it has been going on. The PATIENT sends this link from their own phone, and only if they gave permission. Their answers go to the audiologist and are never shown to the patient

Questions

Kelly Breese, Au.D. · Doc Side Audiology, LLC · (941) 366-2240 · drkelly@docsideaud.com

Sarasota · 2085 Siesta Dr., Ste. 3, FL 34239 **Sun City Center** · 815 Cypress Village Blvd., Ste. A, FL 33573

Call or text (941) 366-2240 · Both offices by appointment only

Patient name

Date of birth

Today's date

Welcome to Doc Side Audiology

This replaces the paper packet. It takes about 5 minutes, saves as you go, and you can finish it on a phone, tablet, or computer. Questions marked * are required.

Which office are you being seen at? *

- ◯ **Sarasota** 2085 Siesta Dr., Ste. 3 · by appointment only
- ◯ **Sun City Center** 815 Cypress Village Blvd., Ste. A · by appointment only
- ◯ **Not sure yet** We'll confirm when we schedule you

Date of your appointment (if you know it)

mm/dd/yyyy

Who is completing this form? *

- ◯ **The patient**
- ◯ **A spouse, family member, or legal representative**

Your name *

Relationship to patient *

Do you have legal authority to sign on the patient's behalf? (POA, guardian, health care surrogate)

- ◯ **Yes**
- ◯ **No**

About you

Legal first name *

Legal last name *

Name you prefer to be called

Optional

Date of birth *

mm/dd/yyyy

Street address *

Apt / Unit | **City** * | **ZIP** *

State *

How to reach you

Cell phone * | **Home phone**

Email address

Best way to reach you *

- ◯ Text message
- ◯ Phone call
- ◯ Email
- ◯ Postal mail

Seasonal residents

If you spend part of the year out of state, tell us when and where so we can time your re-care appointments and ship supplies to the right address.

Do you live out of state part of the year?

- ◯ Yes
- ◯ No

Away roughly from — e.g. May

Away roughly until — e.g. October

Out-of-state mailing address — Street, City, State, ZIP

Your care team

How did you hear about us? *

- ◯ Referred by a physician
- ◯ Online search or website
- ◯ Another audiologist, hearing aid office, or clinic
- ◯ Other
- ◯ Friend or family member
- ◯ Social media
- ◯ Drove or walked by

If someone referred you, who may we thank? — Optional — we love to say thank you

Physicians

Primary care physician | **Their phone**

Have you seen an ENT (ear, nose & throat physician)?

◯ Yes ◯ No

ENT name

Approximate date last seen

How we work

Doc Side Audiology is a private-pay practice. We do not participate with insurance plans and we do not file claims. Payment is due at your visit, and we will give you an itemized receipt with the appropriate codes on request if you would like to submit it to your own plan.

This is a deliberate choice. It is what lets us give you a complete test battery, unhurried appointment time, and a plan built around your ears rather than around what a health plan will authorize. You will see the full financial policy before you sign, and we are always happy to talk through cost before anything is scheduled.

Who we may talk to

Federal privacy law (HIPAA) limits who we may share your health information with. Naming people here lets us return their calls, discuss your results, and let them pick up supplies or devices for you. You can change or cancel this at any time in writing.

Authorized person #1

Name

Relationship

Phone

What may we discuss with this person?

- ☐ Schedule and confirm appointments
- ☐ Billing and payment
- ☐ Test results and treatment plan
- ☐ Pick up hearing aids, supplies, or paperwork

Authorized person #2

Name

Relationship

Phone

What may we discuss with this person?

- ☐ Schedule and confirm appointments
- ☐ Billing and payment
- ☐ Test results and treatment plan
- ☐ Pick up hearing aids, supplies, or paperwork

Emergency contact — name *

Relationship *

Phone *

May we send your audiology reports to the physicians listed on the previous page? *

◯ Yes ◯ No

Why you're coming in

In your own words, what brings you in today? *

Example: I struggle to follow conversation at restaurants and my wife says the TV is too loud.

Check everything that applies to you *

Check at least one. Most people check several.

- ☐ I have concerns with my hearing or understanding TV, groups, phone, background noise, one-on-one
- ☐ Others are concerned about my hearing or understanding
- ☐ Dizziness, vertigo, or balance problems
- ☐ Family history of hearing loss
- ☐ Certain everyday sounds make me angry, anxious, or upset Chewing, gum popping, sniffing, pen clicking, silverware on dishes
- ☐ Ear surgery, ear tubes, or repeated ear infections
- ☐ Ear pain or pressure
- ☐ Hearing loss or tinnitus clearly worse in one ear
- ☐ People seem to mumble, don't speak up, or I ask them to repeat
- ☐ Ringing, buzzing, or other noise in my ear(s) or head (tinnitus)
- ☐ History of noise exposure Military, concerts, farm or shop equipment, woodworking, motorcycles, firearms
- ☐ Ear wax build-up
- ☐ Ordinary sounds are physically too loud or uncomfortable for me Dishes, traffic, a vacuum — not annoying, but painfully loud
- ☐ Drainage, bleeding, or discharge from an ear
- ☐ Sudden hearing change within the last 90 days

Tell us about the ear surgery, tubes, or infections

What was done, which ear, and roughly when

A little more detail

How long have you noticed the problem? *

◯ Less than 3 months ◯ 3 to 12 months

◯ 1 to 5 years ◯ More than 5 years

Which ear is worse? *

◯ Left ◯ Right ◯ About the same ◯ Not sure

Where is listening hardest? (check all that apply)

- ☐ Restaurants and noisy places
- ☐ Television
- ☐ One-on-one conversation
- ☐ Soft or high-pitched voices
- ☐ Groups and meetings
- ☐ Telephone
- ☐ Worship services, theaters, lectures

What you may be missing

Hearing is not only about volume. It is about the life around it. Please answer honestly — there is no wrong answer here.

1 I miss parts of conversations, or I answer and realize I heard it wrong

Never | Sometimes | Often | Almost always

2 I have decided not to go somewhere, or left early, because of my hearing

Never | Sometimes | Often | Almost always

3 I let someone else talk, order, or answer for me

Never | Sometimes | Often | Almost always

4 I feel frustrated, embarrassed, or left out because of my hearing

Never | Sometimes | Often | Almost always

5 People close to me say my hearing gets in the way of our time together

Never | Sometimes | Often | Almost always

Is there anything else you feel you are missing out on, or have stopped doing?

Example: I stopped going to my book club. I don't answer the phone anymore. I sit out of card night.

If we could give you back ONE situation, what would it be?

Example: Sunday dinner with my grandkids

Hearing difficulty is rarely a solo problem — the people around you often notice things you cannot, because they are on the other side of the conversation. With **your permission only**, we like to send five short questions to someone who knows you well. Their answers go to your audiologist, not to you, and this is completely optional.

May we send five short questions to someone close to you?

◯ Yes ◯ No

Their name _____

Their relationship to you

Spouse, daughter, close friend

Their cell number

Their email

Send it to them yourself

You send the link — it comes from your phone, not from us, so nothing about you leaves this page. Their answers go straight to your audiologist. It takes them about three minutes.

Text them the link | Email them the link | Copy the link

Hearing aid history

Have you ever worn hearing aids? *

- ◯ Never
- ◯ In the past, but not now
- ◯ Yes, I wear them now
- ◯ I've tried over-the-counter or online devices

Brand and model (if known)

How old are they?

What made you stop wearing them?

Which device did you try, and how did it go?

Medical history, surgeries, treatments, or medications related to your hearing, balance, or ears

Include diabetes, blood thinners, chemotherapy, autoimmune conditions, head injury, or ear-related medications.

Do any of these apply? (important for safe wax removal)

- ☐ I take a blood thinner
- ☐ I have ear tubes
- ☐ I have diabetes
- ☐ I have a hole or perforation in an eardrum
- ☐ I have had ear surgery in the last 12 months
- ☐ I have an immune condition or take immune-suppressing medication
- ☐ None of these

CONDITIONAL SECTION — About Your Tinnitus

Appears only if the patient checks “Ringing, buzzing, or other noise in my ear(s) or head” on the Reason for Visit page. Once checked, every question in this section is REQUIRED.

About your tinnitus

> *"Tinnitus is not something you have to learn to live with. It is something we can work on together."*
>
> **Dr. Kelly Breese, Au.D., CCC-A, F-AAA**
>
> Certificate Holder in Tinnitus Management

If you hear more than one sound, answer for the **one that bothers you most**. There are no wrong answers — the detail you give here shapes what we do at your visit.

Is your tinnitus present: *

◯ Constantly ◯ Off and on

When it comes on, how long does it last?

_____

Where is your tinnitus located? (choose one) *

◯ Left ear only
◯ Right ear only
◯ Both ears equally
◯ Both ears, worse in the left
◯ Both ears, worse in the right
◯ Middle of the head
◯ In the head, no exact place
◯ More on the right side of the head
◯ More on the left side of the head
◯ Outside of the head

What does the tinnitus sound like?

Ringing, hissing, buzzing, crickets, whooshing, humming…

Does it fluctuate in pitch or intensity?

☐ It fluctuates in pitch
☐ It fluctuates in intensity
☐ It does not fluctuate

Is the tinnitus pulsatile? (does it beat in time with your heartbeat?) *

◯ Yes ◯ No

Tinnitus history

When did you first become aware of the tinnitus?

_____

Was the onset sudden or gradual?

◯ Sudden ◯ Gradual

What do you consider to have started the tinnitus?

_____

When did the tinnitus first become disturbing to you?

_____

Has the intensity changed over time?

◯ No ◯ Yes — worse ◯ Yes — better

What, if anything, makes your tinnitus worse?

What, if anything, makes your tinnitus better?

Do you have TMJ, jaw pain, or grinding or clicking in the jaw?

◯ Yes ◯ No

Who have you consulted regarding your tinnitus?

What have previous professionals said your tinnitus is due to?

Treatments you have tried

- ☐ TRT (tinnitus retraining therapy)
- ☐ Counseling
- ☐ Music therapy
- ☐ Lenire
- ☐ Phone app or white-noise machine
- ☐ None
- ☐ Hearing aids
- ☐ Masking or sound therapy
- ☐ Acupuncture or chiropractic
- ☐ Levo System
- ☐ Supplements (Lipo-Flavonoid, ginkgo, zinc, etc.)
- ☐ Other

How successful did you find these treatments?

Have you discussed your tinnitus with friends or family?

◯ Yes ◯ No

What was their reaction?

How it affects you

18 **On a scale of 0–10, what is your typical annoyance level from your tinnitus?**

Not annoying at all — *Extremely annoying*

0	1	2	3	4	5	6	7	8	9	10

19 **Over the past week, what percentage of the time you were awake were you aware of your tinnitus?**

None of the time — *All of the time*

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

20 **Over the past week, what percentage of the time you were awake were you disturbed by your tinnitus?**

None of the time — *All of the time*

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

When are you most bothered by your tinnitus?

- ☐ When I wake up
- ☐ When I go to bed
- ☐ When I have to concentrate
- ☐ At work
- ☐ Social activities around noise
- ☐ In quiet rooms
- ☐ Other

Does your tinnitus interfere with any of these? (check all that apply)

- ☐ Work
- ☐ Family
- ☐ Social activities
- ☐ Leisure activities
- ☐ Sleep
- ☐ Physical activities
- ☐ None

Anything you'd like to explain further?

Mood and wellbeing

Tinnitus and mood are closely linked. These answers help us treat you properly and stay between you and your audiologist.

Are you experiencing depression or anxiety? *

◯ Yes ◯ No

Are you currently receiving treatment for it?

Do you feel your tinnitus is related?

◯ Yes ◯ No

Are you experiencing any thoughts of harming yourself? *

◯ Yes ◯ No

> **Please read this.** You are not alone, and help is available right now. In the U.S. you can call or text **988** (Suicide & Crisis Lifeline) any time, day or night, or call 911 in an emergency. Dr. Breese will also follow up with you personally about this answer.

Are you currently taking benzodiazepines or recreational drugs?

◯ Yes ◯ No

Which ones?

Is there anything else you would like us to know?

CONDITIONAL SECTION — Tinnitus Handicap Inventory

Appears only if the patient checks “Ringing, buzzing, or other noise in my ear(s) or head” on the Reason for Visit page. Once checked, every question in this section is REQUIRED.

Tinnitus Handicap Inventory

The purpose of this questionnaire is to identify difficulties you may be experiencing because of your tinnitus. **Please answer every question — do not skip any.**

1 **Because of your tinnitus, is it difficult for you to concentrate?**

Yes | Sometimes | No

2 **Does the loudness of your tinnitus make it difficult for you to hear people?**

Yes | Sometimes | No

3 **Does your tinnitus make you angry?**

Yes | Sometimes | No

4 **Does your tinnitus make you feel confused?**

Yes | Sometimes | No

5 **Because of your tinnitus, do you feel desperate?**

Yes | Sometimes | No

6 **Do you complain a great deal about your tinnitus?**

Yes | Sometimes | No

7 **Because of your tinnitus, do you have trouble falling to sleep at night?**

Yes | Sometimes | No

8 **Do you feel as though you cannot escape your tinnitus?**

Yes | Sometimes | No

9 **Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies)?**

Yes | Sometimes | No

10 **Because of your tinnitus, do you feel frustrated?**

Yes | Sometimes | No

11 **Because of your tinnitus, do you feel that you have a terrible disease?**

Yes | Sometimes | No

12 **Does your tinnitus make it difficult for you to enjoy life?**

Yes | Sometimes | No

13 **Does your tinnitus interfere with your job or household responsibilities?**

Yes | Sometimes | No

14 **Because of your tinnitus, do you find that you are often irritable?**

Yes | Sometimes | No

15 **Because of your tinnitus, is it difficult for you to read?**

Yes | Sometimes | No

16 **Does your tinnitus make you upset?**

Yes | Sometimes | No

17 **Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?**

Yes | Sometimes | No

18 **Do you find it difficult to focus your attention away from your tinnitus and on other things?**

Yes | Sometimes | No

19 **Do you feel that you have no control over your tinnitus?**

Yes | Sometimes | No

20 **Because of your tinnitus, do you often feel tired?**

Yes | Sometimes | No

21 **Because of your tinnitus, do you feel depressed?**

Yes | Sometimes | No

22 **Does your tinnitus make you feel anxious?**

Yes | Sometimes | No

23 **Do you feel that you can no longer cope with your tinnitus?**

Yes | Sometimes | No

24 **Does your tinnitus get worse when you are under stress?**

Yes | Sometimes | No

25 **Does your tinnitus make you feel insecure?**

Yes | Sometimes | No

Tinnitus Handicap Inventory — Newman, C.W., Jacobson, G.P., & Spitzer, J.B. (1996). Archives of Otolaryngology–Head & Neck Surgery, 122, 143–148. Wording reproduced verbatim.

CONDITIONAL SECTION — Tinnitus Functional Index
Appears only if the patient checks “Ringing, buzzing, or other noise in my ear(s) or head” on the Reason for Visit page. Once checked, every question in this section is REQUIRED.

Tinnitus Functional Index

Read each question carefully and choose **one** number. These questions are about the **past week**.

Intrusiveness

Over the PAST WEEK…

1 **What percentage of your time awake were you consciously AWARE OF your tinnitus?**

Never aware — *Always aware*

0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100%

2 **How STRONG or LOUD was your tinnitus?**

Not at all strong or loud — *Extremely strong or loud*

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10

3 **What percentage of your time awake were you ANNOYED by your tinnitus?**

None of the time — *All of the time*

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Sense of Control

Over the PAST WEEK…

4 **Did you feel IN CONTROL in regard to your tinnitus?**

Very much in control — *Never in control*

0	1	2	3	4	5	6	7	8	9	10

5 **How easy was it for you to COPE with your tinnitus?**

Very easy to cope — *Impossible to cope*

0	1	2	3	4	5	6	7	8	9	10

6 **How easy was it for you to IGNORE your tinnitus?**

Very easy to ignore — *Impossible to ignore*

0	1	2	3	4	5	6	7	8	9	10

Cognitive

Over the PAST WEEK, how much has your tinnitus interfered with…

7 **Your ability to CONCENTRATE?**

Did not interfere — *Completely interfered*

0	1	2	3	4	5	6	7	8	9	10

8 **Your ability to THINK CLEARLY?**

Did not interfere — *Completely interfered*

0	1	2	3	4	5	6	7	8	9	10

9 **Your ability to FOCUS ATTENTION on other things besides your tinnitus?**

Did not interfere — *Completely interfered*

0	1	2	3	4	5	6	7	8	9	10

Sleep

Over the PAST WEEK…

10 **How often did your tinnitus make it difficult to FALL ASLEEP or STAY ASLEEP?**

Never had difficulty — *Always had difficulty*

0	1	2	3	4	5	6	7	8	9	10

11 **How often did your tinnitus cause you difficulty in getting AS MUCH SLEEP as you needed?**

Never had difficulty — *Always had difficulty*

0	1	2	3	4	5	6	7	8	9	10

12 **How much of the time did your tinnitus keep you from SLEEPING as DEEPLY or as PEACEFULLY as you would have liked?**

None of the time *All of the time*

0	1	2	3	4	5	6	7	8	9	10

Auditory

Over the PAST WEEK, how much has your tinnitus interfered with…

13 **Your ability to HEAR CLEARLY?**

Did not interfere *Completely interfered*

0	1	2	3	4	5	6	7	8	9	10

14 **Your ability to UNDERSTAND PEOPLE who are talking?**

Did not interfere *Completely interfered*

0	1	2	3	4	5	6	7	8	9	10

15 **Your ability to FOLLOW CONVERSATIONS in a group or at meetings?**

Did not interfere *Completely interfered*

0	1	2	3	4	5	6	7	8	9	10

Relaxation

Over the PAST WEEK, how much has your tinnitus interfered with…

16 **Your QUIET RESTING ACTIVITIES?**

Did not interfere *Completely interfered*

0	1	2	3	4	5	6	7	8	9	10

17 **Your ability to RELAX?**

Did not interfere *Completely interfered*

0	1	2	3	4	5	6	7	8	9	10

18 **Your ability to enjoy “PEACE AND QUIET”?**

Did not interfere *Completely interfered*

0	1	2	3	4	5	6	7	8	9	10

Quality of Life

Over the PAST WEEK, how much has your tinnitus interfered with…

19 **Your enjoyment of SOCIAL ACTIVITIES?**

Did not interfere *Completely interfered*

0	1	2	3	4	5	6	7	8	9	10

20 **Your ENJOYMENT OF LIFE?**

Did not interfere *Completely interfered*

0	1	2	3	4	5	6	7	8	9	10

21 **Your RELATIONSHIPS with family, friends and other people?**

Did not interfere — *Completely interfered*

0	1	2	3	4	5	6	7	8	9	10

22 **How often did your tinnitus cause you to have difficulty performing your WORK OR OTHER TASKS, such as home maintenance, school work, or caring for children or others?**

Never had difficulty — *Always had difficulty*

0	1	2	3	4	5	6	7	8	9	10

Emotional

Over the PAST WEEK…

23 **How ANXIOUS or WORRIED has your tinnitus made you feel?**

Not at all anxious or worried — *Extremely anxious or worried*

0	1	2	3	4	5	6	7	8	9	10

24 **How BOTHERED or UPSET have you been because of your tinnitus?**

Not at all bothered or upset — *Extremely bothered or upset*

0	1	2	3	4	5	6	7	8	9	10

25 **How DEPRESSED were you because of your tinnitus?**

Not at all depressed — *Extremely depressed*

0	1	2	3	4	5	6	7	8	9	10

CONDITIONAL SECTION — How You're Doing
Shown to EVERY patient. Not conditional.

How you've been feeling

Tinnitus, sound sensitivity, and dizziness are closely tied to mood — treating one without looking at the other rarely works. These four questions are standard, brief, and stay between you and your audiologist.

Over the last 2 weeks, how often have you been bothered by the following problems?

1 **Little interest or pleasure in doing things**

Not at all	Several days	More than half the days	Nearly every day

2 **Feeling down, depressed, or hopeless**

Not at all	Several days	More than half the days	Nearly every day

3 **Feeling nervous, anxious, or on edge**

Not at all	Several days	More than half the days	Nearly every day

4 **Not being able to stop or control worrying**

Not at all	Several days	More than half the days	Nearly every day

There are no right answers and nothing here is a diagnosis. If anything you marked is weighing on you, please say so at your visit — or sooner. In the U.S. you can call or text **988** any time.

PHQ-2 and GAD-2 — Spitzer, Kroenke & Williams. Public domain; no permission required to reproduce.

CONDITIONAL SECTION — Sound Sensitivity
Appears only if the patient checks “Certain everyday sounds make me angry, anxious, or upset” OR “Ordinary sounds are physically too loud or uncomfortable for me.” Once checked, REQUIRED.

Sound sensitivity

You told us that certain sounds affect you. These questions help us tell apart the different reasons that happens — they are treated very differently, and getting it right matters.

Which sounds set you off?

Check any that apply. Most people check several. Answer for sounds that trigger a **reaction** in you, not just sounds you mildly dislike.

Eating and mouth sounds

- ☐ **Chewing**
- ☐ **Slurping or sipping**
- ☐ **Lip smacking**
- ☐ **Silverware on dishes or teeth**
- ☐ **Crunchy or loud foods**
- ☐ **Swallowing or gulping**
- ☐ **Gum chewing or popping**

Nose and throat sounds

- ☐ **Breathing**
- ☐ **Throat clearing**
- ☐ **Nose whistling**
- ☐ **Sniffing**
- ☐ **Coughing**
- ☐ **Yawning**

Other sounds people make

- ☐ **Keyboard typing**
- ☐ **Finger or foot tapping**
- ☐ **Whispering or “S” sounds**
- ☐ **Humming or throat noises**
- ☐ **Pen clicking**
- ☐ **Knuckle cracking**
- ☐ **Footsteps**

Repetitive sounds not made by people

- [ ] Clock ticking
- [ ] Fan, refrigerator, or appliance hum
- [ ] Muffled bass or TV through a wall
- [ ] Running or dripping water
- [ ] Dog licking or scratching
- [ ] Turn signal or beeping

Things you see rather than hear

- [ ] Leg bouncing or jiggling
- [ ] Watching someone chew
- [ ] Fidgeting or repetitive movement
- [ ] Hair twirling

Any other trigger we didn't list

_____

Does it matter WHO is making the sound? *

- ◯ **Worst with family or my partner** Very common — this does not mean anything is wrong with your relationships
- ◯ **Certain specific people**
- ◯ **Anyone, including strangers**
- ◯ **It makes no difference**

What happens when you hear it

What do you feel? (check all that apply) *

- [ ] Irritation or annoyance
- [ ] Rage — far more than the situation deserves
- [ ] Anxiety or panic
- [ ] Sadness or feeling like crying
- [ ] Anger
- [ ] Disgust
- [ ] Feeling trapped or desperate to get away

What does your body do?

- [ ] Heart races
- [ ] Sweating
- [ ] Feeling hot or flushed
- [ ] Nothing physical that I notice
- [ ] Muscles tighten — jaw, shoulders, fists
- [ ] Chest tightness or trouble breathing
- [ ] Skin crawling or goosebumps

What do you do about it? *

- [ ] Leave the room
- [ ] Put in headphones, music, or a fan
- [ ] Snap at them or lose my temper
- [ ] Avoid the situation entirely from then on
- [ ] Cover my ears
- [ ] Ask the person to stop
- [ ] Mimic or copy the sound
- [ ] Say nothing and endure it

1 **At its worst, how strong is your reaction?**

Barely notice it *The worst feeling I know*

0	1	2	3	4	5	6	7	8	9	10

When it started, and what it costs you

How old were you when it started? *

- ◯ Childhood (before about 12)
- ◯ Teenage years
- ◯ Adulthood
- ◯ I'm not sure

Since then it has: *

- ◯ Gotten worse
- ◯ Stayed about the same
- ◯ Gotten better
- ◯ Comes and goes

Has it changed what you do? (check all that apply) *

- ☐ I eat separately, or avoid eating with others
- ☐ I avoid restaurants
- ☐ It affects my work or school
- ☐ I sleep in a separate room, or can't sleep
- ☐ I avoid cars, planes, or shared travel
- ☐ I avoid movies, worship services, or theaters
- ☐ It has caused arguments or strain with someone close to me
- ☐ I turn down invitations because of it
- ☐ None of these

Do you hide this from people because you're embarrassed by it?

- ◯ Yes
- ◯ No

Two important differences

These separate misophonia from other sound conditions we treat differently.

Think about a sound that bothers you. Is the problem the LOUDNESS, or the SOUND ITSELF? *

- ◯ The sound itself — it would bother me even played quietly
- ◯ The loudness — ordinary sounds are physically too loud or painful
- ◯ Both, depending on the sound

Do you find yourself afraid of sounds, or dreading sounds before they happen? *

- ◯ No
- ◯ Sometimes — I brace for it
- ◯ Yes — I worry about sound a lot of the time

Do ordinary sounds ever cause actual ear pain? *

- ◯ Yes
- ◯ No

Do you also have ringing or noise in your ears (tinnitus)? *

- ◯ Yes
- ◯ No

What you've already tried

- ☐ Ear plugs or noise-cancelling headphones
- ☐ White noise, fan, or background music
- ☐ Counseling or therapy (CBT, exposure)
- ☐ Tinnitus retraining therapy or sound therapy
- ☐ Medication
- ☐ Apps or online programs
- ☐ Just avoiding the triggers
- ☐ Nothing yet

What helps most, even a little?

Anything else you want us to know about how this affects you?

Misophonia is a recognized condition with an agreed clinical definition — it is not a character flaw, and you are not being difficult. Bring this form with you and we will talk through what actually helps.

CONDITIONAL SECTION — Balance & Dizziness
Appears only if the patient checks “Dizziness, vertigo, or balance problems.” Once checked, REQUIRED.

Balance & dizziness

Which best describes what you feel? (check all that apply) *

- ☐ Spinning — the room moves (vertigo)
- ☐ Unsteady or off-balance when walking
- ☐ Worse in busy visual places (stores, patterns, crowds)
- ☐ Lightheaded or faint
- ☐ Floating or rocking, like being on a boat

How long does an episode usually last? *

- ◯ Seconds
- ◯ Minutes
- ◯ Hours
- ◯ Days
- ◯ Constant

What sets it off? (check all that apply)

- ☐ Rolling over or getting out of bed
- ☐ Standing up quickly
- ☐ Loud sounds or pressure changes
- ☐ Looking up or bending over
- ☐ Turning my head
- ☐ Nothing in particular

Does the dizziness come with any of these?

- ☐ Hearing change or fullness in an ear
- ☐ Nausea or vomiting
- ☐ Double vision, numbness, or trouble speaking
- ☐ Tinnitus getting louder
- ☐ Headache or migraine
- ☐ None of these

Falls

Have you fallen in the past 12 months? *

- ◯ No
- ◯ Once
- ◯ Two or more times

Do you limit activities because you are afraid of falling? *

- ◯ Yes
- ◯ No

Do you use a cane, walker, or other support?

- ◯ Yes
- ◯ No

If you have fallen more than once, or a fall caused an injury, please tell the front desk when you arrive so we can allow extra time and assist you safely.

Headache and ear symptoms with your dizziness

These separate the two most commonly confused causes.

Do you get migraines, or headaches bad enough to stop you? *

- ◯ Yes
- ◯ No

During a dizzy spell, do you also get any of these?

- ☐ Bothered by bright light
- ☐ Bothered by sound
- ☐ Visual aura — zigzags, spots, blind patches
- ☐ Headache during or just after the spell
- ☐ I have always been prone to motion sickness
- ☐ None of these

Do you get any of these in an ear when the dizziness comes on?

- ☐ Fullness or pressure in one ear
- ☐ Hearing drops, then comes back
- ☐ Tinnitus gets louder or changes pitch
- ☐ Sound becomes muffled or distorted
- ☐ None of these

Which best describes the pattern over time? *

- ◯ Distinct attacks with completely normal spells in between
- ◯ More or less constant unsteadiness
- ◯ Constant unsteadiness with worse attacks on top
- ◯ One single episode that has not come back

Medications and standing up

Some of the most common causes of dizziness have nothing to do with the inner ear.

Does it happen mainly when you stand up from sitting or lying down? *

- ◯ Yes
- ◯ No

Do you take any of these? (check all that apply)

- ☐ Blood pressure medication
- ☐ A water pill (diuretic)
- ☐ Sleeping tablets, or medication for anxiety
- ☐ An antidepressant
- ☐ A pain medication such as an opioid
- ☐ Antihistamines or motion sickness tablets
- ☐ None of these

Roughly how many prescription medications do you take daily? *

- ◯ None
- ◯ 1 to 3
- ◯ 4 to 6
- ◯ 7 or more

Has a medication been started or changed in the last 3 months?

- ◯ Yes
- ◯ No

What has already been done

So we do not repeat tests you have already had, and so we know who else is involved.

Who have you already seen for the dizziness?

- ☐ My primary care physician
- ☐ A neurologist
- ☐ A vestibular or balance physical therapist
- ☐ No one yet
- ☐ An ENT
- ☐ A cardiologist
- ☐ The emergency room

Which of these tests have you had?

- ☐ Balance testing with goggles or warm/cool air in the ears (VNG or ENG)
- ☐ Rotary chair
- ☐ MRI or CT of the head
- ☐ Blood work for the dizziness
- ☐ I am not sure what I had
- ☐ VEMP testing
- ☐ Head-impulse test with goggles (vHIT)
- ☐ Tilt table or heart monitor
- ☐ None of these

Where and roughly when were those done, and what were you told?

Example: VNG at Sarasota ENT, spring 2024 — they said it was normal.

What has been tried, and did it help?

- ☐ Repositioning manoeuvre (Epley) — the head-turning treatment
- ☐ A water pill for the ears
- ☐ Migraine diet or migraine medication
- ☐ Injection into the ear
- ☐ Nothing has been tried
- ☐ Meclizine or Antivert
- ☐ Low-salt diet
- ☐ Balance exercises or vestibular therapy
- ☐ Ear surgery for the dizziness

Which of those helped, and by how much?

How it affects your day

Answer for the last month.

1 I hold onto walls, furniture, or another person when I walk

Never	Sometimes	Often	Almost always

2 I am unsteady on stairs, curbs, or uneven ground

Never	Sometimes	Often	Almost always

3 I feel worse in the dark, or getting up at night

Never	Sometimes	Often	Almost always

4 I feel worse in busy places — grocery aisles, crowds, patterned floors

Never	Sometimes	Often	Almost always

5 I avoid bending, reaching up, or turning my head quickly

Never	Sometimes	Often	Almost always

6 Showering, dressing, or household tasks are harder because of the dizziness

Never	Sometimes	Often	Almost always

Have you avoided driving, or felt unsafe driving, because of the dizziness? *

◯ Yes ◯ No

Has the dizziness caused you to miss work, or to stop an activity you used to do?

◯ Yes ◯ No

Anything else the dizziness has changed for you?

Privacy & consents

Please read each section and check the box to agree. You may ask us for a paper copy of anything on this page at any time.

1. Notice of Privacy Practices

Doc Side Audiology, LLC maintains a Notice of Privacy Practices describing how your protected health information may be used and disclosed, and your rights regarding it — including your right to see and copy your records, request a correction, ask us to contact you a particular way, and be told if your information is ever breached.

The full Notice is **posted in each office**, available at **docsideaud.com**, and we will give or send you a copy any time you ask. Current version effective **January 1, 2026**.

☐ **I acknowledge that the Notice of Privacy Practices has been made available to me and that I have had the opportunity to read it.**

Would you like your own copy of the full Notice? *

◯ No thank you
◯ Yes — print one for me at my visit
◯ Yes — email it to me

2. How we may contact you

These are three **separate** permissions. You may agree to any of them independently, and you may change your mind at any time by telling us or replying **STOP** to any text.

Please note: standard text messages and standard email are **not encrypted**. There is some risk that a person other than you could see the message. Choosing these methods means you accept that risk. Message and data rates may apply and message frequency varies. **Consenting is never a condition of receiving care from us.**

A. Appointment and care messages *

- ☐ **Phone calls (including automated or prerecorded reminders)**
- ☐ **Text messages to my cell phone**
- ☐ **Email**
- ☐ **None of these — mail or in person only**

B. Voice messages *

- ◯ **Leave a detailed message** Appointment times, test results, device or repair status, and supply notices may be left on my voicemail or sent as a voice message.
- ◯ **Leave a brief message only** Say who is calling and ask me to call back — no health details.
- ◯ **Do not leave any message** Call, but hang up without leaving a message.

C. News, promotions, and events *

- ◯ **Yes — send me product news, promotions, and event invitations**
- ◯ **No thank you**

3. Cerumen management & earmold impressions

Cerumen (earwax) removal and earmold impressions both involve placing instruments or material into your ear canal. Your Board Certified Doctor of Audiology follows accepted professional protocols to avoid adverse results, and these are straightforward, commonly performed procedures.

Possible risks, though uncommon, include: discomfort or tenderness; brief dizziness; coughing; minor bleeding or a scratch of the ear canal skin; temporary increase in tinnitus; and rarely infection, or a perforation of the eardrum or retained impression material requiring physician care.

Please tell your audiologist before the procedure if you take blood thinners, have a perforated eardrum or ear tubes, have had ear surgery, have diabetes or an immune condition, or have had a bad reaction to ear cleaning in the past. You may decline or stop the procedure at any time.

- ☐ **I have read and understand the notice above, I recognize the risks described, and I consent to these procedures when my audiologist recommends them.**

4. Financial policy

We are a private-pay practice. Doc Side Audiology, LLC does not participate with insurance plans and does not file claims on your behalf. We chose this deliberately: it lets us give you a complete diagnostic battery, unhurried appointment time, and recommendations driven by your hearing rather than by what a plan will authorize.

Payment. Payment is due at the time of service. We accept cash, check, and major credit cards. You are welcome to ask what anything costs before it is scheduled, and we will tell you.

Receipts you can submit yourself. On request we will provide an itemized receipt showing the services provided and the appropriate codes, so that you may submit it to your own plan for whatever out-of-network reimbursement it offers. Whether you are reimbursed, and how much, is between you and your plan. We cannot guarantee payment, and we do not file or appeal claims.

Third-party hearing benefit programs. Some plans offer a hearing benefit administered by an outside company. These programs often limit which devices may be dispensed, how much testing is allowed, and how much follow-up care is included. If you have one, tell us — we will look at it with you honestly and tell you plainly whether using it serves your hearing, or whether it would cost you care you actually need.

Appointments. Your appointment time is reserved specifically for you, and time that goes unused cannot be offered to another patient who needs it. Please give us at least **24 hours' notice** if you need to cancel or reschedule. **We do not charge a cancellation fee.** Repeated missed appointments may affect our ability to reserve extended appointment times for you in the future.

Hearing devices. Terms for hearing aid purchases, trial periods, and returns are covered on a separate purchase agreement you will receive if and when you order devices.

☐ **I have read, understand, and agree to the financial policy above. I understand that Doc Side Audiology is a private-pay practice and does not bill insurance.**

CONDITIONAL SECTION — Who You Are
Not part of the patient packet. Reached only through its own link, which the patient texts or emails to a family member from their own phone, and only if they gave permission.

Thank you for helping

Someone you care about is being seen at Doc Side Audiology and gave us permission to ask you five short questions. It takes about three minutes.

You are on the **other side** of every conversation they have. That means you notice things they cannot notice about themselves — and what you tell us here often changes how we plan their care. Please answer honestly. There is nothing unkind about an accurate answer.

Your answers go to their audiologist. We will not forward them to the patient, and we will not share anything about their medical care with you in return.

Patient's first name *

Patient's last name *

Patient's date of birth *

mm/dd/yyyy

Your name *

Your relationship to them *

Spouse, daughter, close friend

How much time do you spend with them in a typical week? *

- ◯ We live together
- ◯ Most days
- ◯ Once or twice a week
- ◯ Less often than that

CONDITIONAL SECTION — What You Notice

Not part of the patient packet. Reached only through its own link, which the patient texts or emails to a family member from their own phone, and only if they gave permission.

What you notice

Think about the last month. There is no right answer — we simply want your view.

1 They miss parts of conversations, or answer something different from what was asked

Never	Sometimes	Often	Almost always

2 They have decided not to go somewhere, or left early, because of their hearing

Never	Sometimes	Often	Almost always

3 I repeat myself, relay what was said, or answer for them

Never	Sometimes	Often	Almost always

4 They seem frustrated, embarrassed, or withdrawn because of their hearing

Never	Sometimes	Often	Almost always

5 Their hearing gets in the way of our time together

Never	Sometimes	Often	Almost always

A few more

1 How ready do you think they are to do something about their hearing?

Not at all ready — *Completely ready*

0	1	2	3	4	5	6	7	8	9	10

2 How much does their hearing difficulty affect YOU?

Not at all — *A very great deal*

0	1	2	3	4	5	6	7	8	9	10

What would you most like to see change?

Example: I would like to stop being the one who repeats everything at dinner.

Is there anything you have noticed that they might not mention to us?

Anything at all — safety, mood, withdrawal, driving, the phone, the doorbell.

Have you had any safety concerns — alarms, doorbells, traffic, or driving?

- ◯ Yes
- ◯ No

Please tell us what happened

Your concern — what, and for how long

A few lines in your own words. This is often the most useful thing on the page.

What concerns you most about their hearing? *

Example: He cannot follow anything at a table of more than three people, and he has stopped trying.

How long has this been going on? *

- ◯ Less than 6 months
- ◯ 6 to 12 months
- ◯ 1 to 3 years
- ◯ 3 to 5 years
- ◯ More than 5 years
- ◯ As long as I have known them

How has it changed over that time? *

- ◯ Slowly getting worse
- ◯ Suddenly worse recently
- ◯ About the same
- ◯ It comes and goes
- ◯ Somewhat better

Was there a particular moment when you first noticed?

Example: Last Christmas he asked three times what his granddaughter had said, then went and sat outside.

Have you talked to them about it?

- ◯ Often — it is a regular source of friction
- ◯ A few times
- ◯ Once, and I left it alone
- ◯ No — I have not wanted to raise it

> Thank you for saying so. Repeated conversations that go nowhere wear on both people. Your audiologist will not repeat this back to them — it helps her understand where they are starting from.

Sign & submit

Your signature applies to every consent on the previous page and confirms that the information you provided is accurate to the best of your knowledge.

Sign in the box *

Sign here

☐ **By signing above I confirm that the information in this packet is accurate to the best of my knowledge, and I agree to the consents and policies it contains. Completed electronically, this signature has the same legal effect as a handwritten one.**

Printed name *

Today's date *

mm/dd/yyyy