From: Henry, J. A., Jastreboff, M. M., Jastreboff, P. J., Schechter, M. A., & Fausti, S. A. (2003). Guide to conducting tinnitus retraining therapy initial and follow-up interviews. *Journal of rehabilitation research and development*, *40*(2), 157-178.

Tinnitus and Decreased Sound Tolerance Follow-up Interview

Name:_____**Date**: _____

These questions will be essentially the same as the questions as your initial evaluation. Recall that we are evaluating three different things: (1) tinnitus, (2) sound tolerance, and (3) hearing. Each question is specific to *tinnitus*, *sound tolerance*, or *hearing*. ***Tinnitus*** refers to any kind of sound in your head—ringing, hissing and so on. ***Sound tolerance*** refers to how you react to different sounds in your environment. ***Hearing*** refers to your ability to detect sounds in your environment, or to your ability to understand the speech of others.

The questions about your tinnitus generally refer to the *last month*. Answer these questions thinking about your tinnitus *over the last month*. Remember that there are *no wrong answers*. If you fill this out before you appointment, we will review these questions at the time of your appointment.

TINNITUS

The first series of questions are specific to your *tinnitus*. Please think only about your *tinnitus* when you answer these questions.

1. Do you have days when your tinnitus is more bothersome than on other days? □ No □ Yes

(IF YES) How often do you have these "bad days?"_____days per week/month

(IF YES) Are they *as frequent* as they were before you started treatment? □ No □ Yes

(IF YES) Are they *as bad* as they were before you started treatment? □ No □ Yes

2. Does any kind of sound have an impact on your tinnitus? That is, does sound make your tinnitus louder or softer or is there no effect?

□ No effect □ Softer □ Louder

(IF "LOUDER" OR "SOFTER") What kind of a sound has an impact on your tinnitus? _____

How long does this last? _____

Is it still louder until *at least* the next morning after you've slept? □ No □ Yes

(IF EFFECT LASTS *AT LEAST* UNTIL NEXT MORNING) Please give an example of the kind of sound that would cause this to happen. _____

3. Do you use ear protection (earplugs or earmuffs)? □ No □ Yes

(IF YES) When do you use ear protection? _____

Why do you use ear protection? _____

(IF EAR PROTECTION IS USED FOR TINNITUS) What percent of the time do you use earplugs or muffs for your tinnitus?_____%

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4. Are you currently receiving any other treatment specifically for your tinnitus? ☐ No ☐Yes

(If YES) What? _____

(**Interviewer:** This can be professional or self-administered "alternative" therapies, e.g., herbs, vitamins, tapes.)

5. I'm going to describe certain activities that may be a part of your life. Please tell me if the tinnitus prevents you from conducting these activities or if your tinnitus negatively affects these activities in any way.

(**Interviewer**: Indicate patient's previous responses. Telling patients "improvement" is ok, but don't tell them previous answers.)

	Prevented	Affected	No Effect
Concentration?	☐	☐	☐
Sleep?	☐	☐	☐
Quiet resting activities (reading, relaxing, etc.)?	☐	☐	☐
Work?	☐	☐	☐
Going to restaurants?	☐	☐	☐
Participating in or observing sports events?	☐	☐	☐
Social activities?	☐	☐	☐
Anything else?_____	☐	☐	☐

People can be *aware* of their tinnitus some of the time and not aware of it at other times.

6. What percent of your *total awake time*, over the last month, have you been *aware* of your tinnitus? Please give an average percentage over the last month._____%

Has this percentage changed since the beginning of treatment? ☐ No ☐ Yes

What percent of your *total awake time*, over the last month, were you

annoyed/distressed/irritated by your tinnitus? Please give an average

percentage over the last month._____%

Has this percentage changed since the beginning of treatment? ☐ No ☐ Yes

I'm now going to ask you to rank your tinnitus, on a scale of 0 to 10, with regard to severity, annoyance, and effect on your life. Please do not include hearing difficulties when you answer these questions.

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7. How *strong*, or *loud*, was your tinnitus, on average, over the last month? "0" would be "no tinnitus"; "10" would be "as loud as you can imagine."

0 1 2 3 4 5 6 7 8 9 10

8. How much has tinnitus *annoyed you*, on average, over the last month? "0" would be "not annoying at all"; "10" would be "as annoying as you can imagine."

0 1 2 3 4 5 6 7 8 9 10

9. How much did tinnitus *affect or impact your life*, on average, over the last month? "0" would be "not at all"; "10" would be "as much as you can imagine."

0 1 2 3 4 5 6 7 8 9 10

10. Do you have any other comments about your tinnitus?

_____

SOUND TOLERANCE

The next series of questions are only about your *ability to tolerate sound*. Please think only about your *sound tolerance* when you answer these questions.

(**Interviewer:** Ask these questions only if patient had a sound tolerance problem at the initial visit.)

11. Describe the sounds that cause you pain or physical discomfort.

_____

12. Do you have days when your sound tolerance is more of a problem than on other days? □ No □ Yes

(IF YES) How often do you have these "bad days"?_____days per _____

(IF YES) Are they *as frequent* as they were before you started treatment? □ No □ Yes

(IF YES) Are they *as bad* as they were before you started treatment? □ No □ Yes

13. Does any kind of sound have an impact on your ability to tolerate sound? That is, does exposure to sound make your sound tolerance better, worse, or is there no effect?

□ No effect □ Better □ Worse

(IF "WORSE" OR "BETTER") What kind of a sound has any kind of impact on your sound tolerance?

_____

How long does this last?

_____

Does the effect last *at least* until the next morning after you've slept? □ No □ Yes

(IF EFFECT LASTS *AT LEAST* UNTIL NEXT MORNING) Please give an example of the kind of sound that would cause this to happen. _____

14. Refer to question 3. If you do not use hearing protection, go to question 16. If you do use hearing protection, continue below:

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Do you use earplugs or earmuffs specifically *because of sound tolerance*? □ No □ Yes

(IF YES) What percent of the time do you use ear protection *because of sound tolerance*?_____%

(IF YES) Do you use your earplugs when it's fairly quiet *because of sound tolerance*? □ No □ Yes

15. Are you currently receiving any other treatment specifically for your *sound tolerance*? □ No □ Yes

(IF YES) What treatment? _____

16. I'm going to describe certain activities that may be a part of your life. Please tell me if the sound tolerance prevents you from conducting these activities, or if your sound tolerance negatively affects these activities in any way.

(**Interviewer:** Underline patient's previous responses. Telling patients "improvement" is ok, but don't tell them previous answers.)

	Prevented	Affected	No Effect
Concerts?	□	□	□
Shopping?	□	□	□
Movies?	□	□	□
Work?	□	□	□
Going to restaurants?	□	□	□
Driving?	□	□	□
Participating in or observing sports events?	□	□	□
Attending church?	□	□	□
Housekeeping activities?	□	□	□
Childcare?	□	□	□
Social activities?	□	□	□

Anything else? _____

I'm now going to ask you to rank your *sound tolerance*, on a scale of 0 to 10, with regard to severity, annoyance, and effect on your life.

17. How *severe* was your sound tolerance, on average, over the last month? "0" would mean "you can tolerate all sounds"; "10" would mean "you cannot tolerate any sounds."

0 1 2 3 4 5 6 7 8 9 10

18. How much has your problem with sound tolerance *annoyed you*, on average, over the last month? "0" would be "not annoying at all"; "10" would be "as annoying as you can imagine."

0 1 2 3 4 5 6 7 8 9 10

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19. How much did sound tolerance affect your life, on average, over the last month? "0" would be "not at all"; "10" would be "as much as you can imagine."

0 1 2 3 4 5 6 7 8 9 10

20. Do you have any other comments about your *sound tolerance*? _____

HEARING

21. Do you think you have a hearing problem? □ No □ Yes

RANKING PROBLEMS

On a scale of 0 to 10, I would like you to rank the importance of tinnitus, sound tolerance, and hearing, with regard to how much they are a problem for you *on average over the last month*. "0" would be "no problem at all"; "10" would be "as much as you can imagine."

22. How much of a problem is *tinnitus*? "0" would be "no problem at all"; "10" would be "as much as you can imagine."

0 1 2 3 4 5 6 7 8 9 10

23. How much of a problem is *sound tolerance*? "0" would be "no problem at all"; "10" would be "as much as you can imagine."

0 1 2 3 4 5 6 7 8 9 10

24. How much of a problem is *hearing*? "0" would be "no problem at all"; "10" would be "as much as you can imagine."

0 1 2 3 4 5 6 7 8 9 10

25. Considering tinnitus, sound tolerance and hearing, would you say your problem in general is the *same, better,* or *worse*? _____

26. How would you feel if you had to give back your instruments? _____

27. Are you glad you started this program? □ No □ Yes □ Not sure

Audiologist to complete:

1. Indicate main problems discussed during this questionnaire:

2. Recommendation:

3. Next visit: