**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 Initial Interview

**Name**:_____ **Date**: _____

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 under- stand 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*. Please know that there are *no wrong answers*. Please understand that if you answer these questions in writing before your appointment, we will go over them in detail during 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.** Where is the location of your tinnitus?

☐ Head ☐ Right ear ☐ Left ear ☐ Both ears

**2.** Is your tinnitus louder on one side of your head than the other?

☐ Right > Left ☐ Left > Right ☐ Both ears

**3.** Is your tinnitus a constant sound or an intermittent sound? ☐ Constant ☐ Intermittent

**4.** Does your tinnitus fluctuate in volume? (i.e., does the volume change *on its own*?) ☐ No ☐Yes

(**IF YES)** How often does it fluctuate?_____times per _____

**5.** Please describe the onset of your tinnitus: ☐ Gradual ☐ Sudden

When did it start? _____

**6.** What does your *most bothersome* tinnitus sound like? _____

**7.** 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

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

☐ No effect ☐ Softer ☐ Louder

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

How long does this last? _____

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Is it still louder until *at least* the next morning after you've slept? No Yes (Circle one.) **(IF EFFECT LASTS *AT LEAST* UNTIL NEXT MORNING)** Please give an example of the kind of sound that would cause this to happen.

_____

**9.** 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*?_____%

Do you use your earplugs or muffs *for your tinnitus* when it's fairly quiet? □ No □ Yes

**10.** Are you currently receiving any other treatment specifically for your tinnitus? □ No □ Yes

**(IF YES)** What? _____

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

**11.** What is the *major reason* your tinnitus is a problem? _____

**12.** 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.

| | 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.

**13.** 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._____%

**14.** What percent of your *total awake time*, over the last month, were you *annoyed, distressed, or irritated* by your tinnitus? Please give an average percentage over the last month._____%

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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.

**15.** 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

**16.** 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

**17.** How much did tinnitus *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

**18.** 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.

**19.** Do you have a *decreased tolerance* to sound? That is, are sounds bothersome or unpleasant to you when they *seem normal to other people* (family and friends) around you? No or Yes **(IF NO, GO TO QUESTION 31.)**

(**Examples:** TV, children screaming, dishes clattering, dishwasher in operation, etc.)

**20. (IF YES)** Do sounds cause you pain or physical discomfort? □ No □ Yes

**21.** 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 _____

**22.** 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. _____

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**23.** (Refer to question 9. If patient does not use hearing protection, go to question 24. If patient does use hearing protection, continue below):

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

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

**(IF YES)** What treatment? _____

**25.** What is the major reason your *sound tolerance* is a problem? _____

**26.** 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.

| | 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.

**27.** 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

**28.** 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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**29.** 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

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

## HEARING

I now have just a few questions about your hearing ability.

**32.** Have you ever worn hearing aids? □ No □ Yes

**33.** Have you ever had hearing aids recommended to you? □ No □ Yes

**(IF YES)** From who: A professional? Family? Friend? _____

## 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."

**34.** 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

**35.** 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

**36.** 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

**Audiologist to fill out:**

1. Indicate patient TRT *category*: _____
2. Recommendation: _____
3. Patient decision: _____
4. Next visit: _____