LENIRE®

Initial Assessment Form

Patient Name:

Phone number:

Date of Consultation: / /

Date of birth: / /

Practitioner:

Tinnitus aspects

How long have you had tinnitus?

- ○ <3 months
- ○ 3 to 6 months
- ○ 6 months to 1 year
- ○ 1 to 2 years
- ○ 2 to 5 years
- ○ 5 to 10 years
- ○ 10 to 20 years
- ○ >20 years
- ○ Not sure

Can you recall where you where or what you were doing when you first became aware of your tinnitus?

Please describe the onset of your tinnitus.

- ○ Gradual
- ○ Abrupt
- ○ Not sure

Please describe the sound of your tinnitus.

- ○ Hissing
- ○ Ringing
- ○ Buzzing
- ○ Whistling
- ○ Humming
- ○ Combination of sounds
- ○ Pure tone
- ○ Difficult to describe
- ○ Other: _____

Please describe the location of your tinnitus.

- ○ Left ear only
- ○ Inside my head
- ○ Right ear worse
- ○ Right ear only
- ○ Can't describe
- ○ Other: _____
- ○ Both ears
- ○ Left ear worse

Please describe the frequency of your tinnitus.

- ○ Constant
- ○ Fluctuating
- ○ Intermittent

What tinnitus treatments have you tried?

- ○ None
- ○ TMJ treatment
- ○ Psychotherapy (i.e. CBT / TRT / counseling / mindfulness)
- ○ Medication (i.e. antidepressants / sleeping pills / antianxiety)
- ○ Hearing devices
- ○ Tinnitus apps
- ○ Alternative therapies (i.e. reflexology / acupuncture)
- ○ Other: _____
- ○ Noise protection
- ○ Sound therapy (i.e. maskers / music / nature sounds)
- ○ Neuromodulation (i.e. transcutaneous / transcranial / bimodal)

Have you started any of the above treatments in the last 3 months?

- ○ Yes
- ○ No

What type of healthcare professional?

Prior to today, have you seen a healthcare professional about your tinnitus?

- ○ Yes
- ○ No

Are you currently seeing a healthcare professional about your tinnitus?

- ○ Yes
- ○ No

Have you been diagnosed with any medical conditions related or unrelated to your tinnitus?

○ Yes ○ No

Please describe:

Are you currently taking medication?

○ Yes ○ No

If yes, please describe:

Have you started this medication in the last three months?

○ Yes ○ No

Have you had an MRI regarding your tinnitus?

○ Yes ○ No

If yes, was the outcome normal?

○ Yes ○ No

If yes, please describe:

Please rate the loudness of your tinnitus (right now) on a scale of 0-10.

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

Please rate the annoyance of your tinnitus (right now) on a scale of 0-10.

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

Sleep

Do you have issues sleeping or insomnia?

○ Yes ○ No

Does your tinnitus impact your sleep?

○ Yes ○ No

On average, how many hours of sleep do you get each night? _____

Did you have any issues with sleep prior to the onset of your tinnitus?

○ Yes ○ No

If yes, please describe:

Psychological

Have you ever experienced feelings of anxiety / stress / depression/ or emotional struggles in general (prior to developing tinnitus)?

○ Yes ○ No

Have you ever experienced feelings of anxiety / stress/ depression as result of your tinnitus?

○ Yes ○ No

Have you been clinically diagnosed with anxiety?

○ Yes ○ No

Have you been clinically diagnosed with depression?

○ Yes ○ No

Audiological

Do you feel you have hearing loss?

○ Yes ○ No ○ Not sure

Do you currently wear hearing aids?

○ Yes ○ No

If yes

○ Both ears ○ Right ear only ○ Left ear only

If yes, were you fit in the last 90 days?

○ Yes ○ No

If no, but hearing aids are recommended, what treatment is a priority for you?

○ Tinnitus ○ Hearing loss

Do you have trouble tolerating certain sounds?

○ Yes ○ No If yes, please describe:

If yes, do these sounds cause physical discomfort?

○ Yes ○ No

Have you been diagnosed with hyperacusis?

○ Yes ○ No If yes, please describe:

Lenire Contraindications

○ Pacemaker, defibrillator or any other active implantable device (unless directed by a doctor)

○ Pregnant (unless directed by a doctor)

○ Epilepsy

○ Condition that may result in loss of consciousness

○ Condition that causes impaired sensitivity of the tongue

○ Lesions of the oral cavity (unless directed by a doctor)

○ Sores of the oral cavity (unless directed by a doctor)

○ Inflammation of the oral cavity (unless directed by a doctor)

○ Any intermittent or chronic neuralgia in the head and neck area

Clinical Outcomes

What would be the first most successful treatment outcome for you?

○ Tinnitus less bothersome ○ Improvement in sleep ○ Improvement in hearing

○ Improvement in concentration ○ Improvement in mood (anxiety / stress / depression / emotional struggles)

What would be the second most successful treatment outcome for you?

○ Tinnitus less bothersome ○ Improvement in sleep ○ Improvement in hearing

○ Improvement in concentration ○ Improvement in mood (anxiety / stress / depression / emotional struggles)

What would be the third most successful treatment outcome for you?

○ Tinnitus less bothersome ○ Improvement in sleep ○ Improvement in hearing

○ Improvement in concentration ○ Improvement in mood (anxiety / stress / depression / emotional struggles)