TINNITUS AND HYPERACUSIS CLINIC

Sound Sensitivity Questionnaire

Name:_____ Date:_____

Medical History

1. Were you involved in any (check all that apply): ☐ Significant events ☐ Accidents ☐ Surgeries ☐ Other
   If yes, please describe the event(s) and the age(s) at which they occurred:

2. Do you have any inherited conditions, congenital disorders, or family history related to auditory function?
   ☐ Yes / ☐ No If yes, explain:

3. Age of onset of symptoms:_____ Please note memory/description of triggers:

4. Please list current medications:

5. Have you consulted any professionals about your sound sensitivity? ☐ Yes / ☐ No
   If yes, whom:

6. Please list any treatments tried for sound sensitivity and their effectiveness:

Triggers

1. Please list the main sounds that cause problems:

2. What have been the worst incidents?

3. Is there a particular person associated with the triggers? ☐ Yes / ☐ No
   If yes, whom:

4. List the reactions experienced or expressed (check all that apply): ☐ Self harm ☐ Flight ☐ Frustration
   ☐ Rage ☐ Verbal or bodily expressions of anger ☐ Sorrow ☐ Confusion ☐ Other:_____

5. How long does it take to recover from the reactions?

Triggers Continued

6. What are the activities or actions that can positively impact the reaction, either in the intensity or duration of the reaction?

7. Best Case Scenario: What activities are the most comfortable for you? When are you happiest?

General Information

1. Do you use (check all that apply): ☐ Earplugs (If so, how often:_____ Type:_____)

   ☐ Ear muffs ☐ Noise cancellation devices (If so, how often:_____ Type:_____)

2. Who lives in the home with you?

3. How does your sound sensitivity impact your day to day life?

4. How does your sound sensitivity impact the others in the household?

5. Do you have related conditions/behaviors/sensitivities? ☐ Yes / ☐ No
   If yes, please list any other sensory related issues:

6. Is there any other information you would like us to know?