CORNERSTONE AUDIOLOGY
Life is Worth Hearing

Patient Intake

Patient Name_____ Date of Birth___/___/_____ Age_____ Male Female

Address_____ City _____ State ____ Zip _____

SSN: XXX-XX-_____ Home Phone (_____) _____-_____ Cell Phone (_____) ____-_____

Email _____ Marital Status: S M D W Spouse's Name _____

**Primary Care Physician (Required) _____ Phone (____) _____-_____

Date last seen by Physician _____

Preferred method of contact: Phone Call Text Email

Emergency Contact:

Name _____ Primary Contact (_____) _____-_____

Relationship to Patient _____ Can records be released to this person? Yes No

How did you hear about us? Please check all that apply and provide name(s) where applicable.

___ Physician Referral _____ ____ Friend _____

___ Newspaper ___ Mail ___Website ___Facebook ____ TV ___ Other _____

Employer:

Name of Business _____ Phone (____) _____-_____

HR Manager _____ ___Retired

Please Initial all 3 places and Sign and Date at the bottom:

_____ **Consent to Treatment**: I agree to the audiological services necessary for care and treatment provided under the general and special instructions of the audiologist.

_____ **Privacy Practices**: Privacy Practices have been reviewed and made available to me. I understand that Cornerstone Audiology may send me educational information on the products and services offered.

_____ **Release of Information**: I, the undersigned, hereby authorize Cornerstone Audiology to release my records to the physician(s) listed above and provide/request updated medical records needed to aid in my evaluation and treatment.

**Responsible Party Signature (required) _____ Date _____

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Case History

HEARING HISTORY:	YES	NO
Is this your first hearing test?		
Have you ever had ear surgery?		
Do you have any pain in your ears?		
Do you have a history of ear infections?		
Do you have a family history of hearing loss?		
Do you have a history of noise exposure?		
Do you have noises in your ears? (i.e. ringing, roaring)		
If so, is it bothersome?		
Have you taken medication that may have affected your hearing?		
Have you noticed dizziness?		
Do you think you have a hearing loss?		
Do you have concerns with memory loss?		
Do you have issues with dexterity? (fine motor skills in hands)		
HEARING AID HISTORY:		
Have you tried hearing aids before?		
Are you currently a hearing aid user?		
Were you satisfied with your hearing aids?		

MEDICAL HISTORY: Please check all that apply

___Heart ___Current use of blood thinner ___Pace Maker

___Allergies ___Cancer ___Diabetes Other _____

Do you have difficulty hearing on your cell phone? YES NO

Make/Model of cell phone _____

Do you know any patients of Cornerstone Audiology? YES NO

If yes, who do you know? _____

Please list situations in which you would like to hear and/or understand better:

_____ _____ _____

Was there any specific event or circumstance that brought you in today?

_____

Is there anything else we should know?

_____

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Hearing Screening Questionnaire

	NO	SOMETIMES	YES
Does a hearing problem cause you to feel embarrassed when you meet new people?			
Does a hearing problem cause you to feel frustrated when talking to members of your family?			
Do you have difficulty hearing/understanding co-workers, clients or customers?			
Do you feel handicapped by a hearing problem?			
Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?			
Does a hearing problem cause you difficulty in the movies or in the theatre?			
Does a hearing problem cause you difficulty when listening to TV or radio?			
Do you feel that your hearing problem limits or hampers your personal or social life?			
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			

If we find your hearing challenges could be helped by hearing devices, would you be open to trying a solution? YES POSSIBLY NO

Please check hearing aid features you may be interested in:

____Invisibility ____Maintenance-Free ____Bluetooth/Smart Phone Streaming

____Rechargeability ____Cost-Effective ____Hearing in Noise