



Communication Sciences and Disorders Speech-Language and Hearing Clinics

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Audiology Clinic: Adult Client Intake Form

Client Information

Legal first name:

Legal last name:

Preferred or lived name:

Pronouns:

Date of Birth:

Occupation:

Phone 1:

Mobile Carrier:

Phone 2:

Mobile Carrier:

Email address:

Mailing Address:

City:

State:

Zip:

Name of Primary Care Provider:

Emergency Contact Name:

Emergency Contact Relationship:

Emergency Contact Phone:

Emergency Contact Email:

If you are completing this form on someone's behalf:

Name of person completing form:

Relationship to client:

Phone:

Email:

Contact person for scheduling or other questions:

Audiology Clinic: Adult Client Case History

1. Reasons for your visit (mark all that apply):

- I am concerned about my hearing
- Others have concerns
- Family history of hearing loss
- Other:
- Hearing aids
- Noise exposure
- Transferring Care

2. Have you ever had your hearing tested?

yes no unsure

If so, when?

Were hearing devices recommended?

yes no

3. Do you have hearing loss?

yes no unknown

Which ears?

right left both

Was it sudden or gradual?

Cause, if known:

4. Do you have difficulty listening in specific situations? (mark all that apply)

- Using the phone
- During quiet conversations
- In groups of people
- Women and children's voices
- Background noise
- Watching television
- Other:

5. Do you have family history of hearing loss before age 50?

yes no unknown

If so, please list family members with hearing loss and their relationship to you:

6. Have you ever worn or tried hearing aids?

yes no

If so, do you still wear them?

yes no

Make and model, if known:

Please describe your experience:

7. Do you have a history of noise exposure? (mark all that apply)

yes no unsure

This includes noise exposure for work, recreation, and hobbies.

- Military/law enforcement
- Firearms
- Industrial machinery
- Power tools
- Concerts
- Other:

Do/did you wear hearing protection?

yes no

Case History – continued

8. Do you have a history of head trauma? yes no

(Examples: concussions, skull fractures, or other head injuries)

If so, please explain:

9. Have you had ear surgery? yes no

If so, which ears?

right left both

Dates and types of surgery:

10. Do you have a history of ear infections? yes no

If so, which ears?

right left both

When did they first occur?

How often?

How were the infections treated?

11. Do you have any health problems, concerns, or conditions?

(Examples: asthma, diabetes, kidney disease, heart disease, lupus)

If so, please list:

12. Please list the name and dosage of any medications or supplements you take:

If you need more room, you may send your medication list as a separate page.

Case History - continued

13. Do you hear ringing, buzzing, or other noises (tinnitus) in your ears? yes no

If yes, please complete the [Tinnitus Addendum](#).

14. Do you experience dizziness, imbalance, or vertigo? yes no

If yes, please complete the [Dizziness Addendum](#).

15. Are you visiting our clinic for cochlear implant candidacy testing or for cochlear implant care? yes no

If yes, please complete the [Cochlear Implant Addendum](#).

16. Are you interested in our hearing aid bank program which provides refurbished/donated hearing aids at no cost? yes no

If yes, please complete the [Hearing Aid Bank Application Addendum](#).

17. What are your goals for hearing health?

18. Anything else we should know?

Please feel free to include any questions or concerns you may have.

Signature of Client or Representative: