**New Client Information Form**

We are committed to providing our clients with the best care.

To do this, it is essential that your personal information is up to date and accurate.

PLEASE CIRCLE ONE OF THE FOLLOWING: MISS MS MRS MR DR

FIRST NAME: SURNAME:

DOB: PENSION/DVA NUMBER:

RESIDENTIAL ADDRESS: \_\_\_\_\_\_\_

HOME PHONE: WORK PHONE: MOBILE: \_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_

Are you happy to receive newsletters, special offers and latest product information via email (sent out) Yes No

OCCUPATION: \_\_\_\_\_\_\_

ALTERNATE CONTACT PERSON:

NAME: RELATIONSHIP: \_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_ MOBILE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU REQUIRE AN INTERPRETER SERVICE Yes No

How did you hear about us? (Please specify)

 Website  Friend/Relative  Online  Yellow Pages  Signage  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your health history:**

**Do you have or have you had a history of?**

Diabetes: Yes No Cancer: Yes No

Mental Illness: Yes No Other: \_\_\_\_\_\_\_\_

Current Prescription Medications: (Doctors Print Out is also sufficient if there is several medications)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Authority**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorise for my clinical records to be sent to:

Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note: Clients attending will be required to pay the private practice fees on the day and seek reimbursement back from Health Funds, Workcover and or Employers.**

**Your Hearing Health**

Do you or your family/friends feel you have a hearing loss? Yes No

If yes, which ear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did it happen suddenly or gradually? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience any forms of ringing in the ears? Yes No

If yes, which ear?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a family history of hearing loss? Yes No

Have you had any pain or discharge from the ears? Yes No

Have you ever had an ear operation?  Yes No

Have you had any vertigo recently? Yes No

Have you ever had any perforations of the ear? Yes No

Have you ever had any ear infections? Yes No

Have you consulted other specialists before? Yes No

Have you had any injuries to the head or ear? Yes No

Have you worked in a noisy environment before? Yes No

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have private health insurance? Yes No

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are some of your weekly activities/hobbies?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

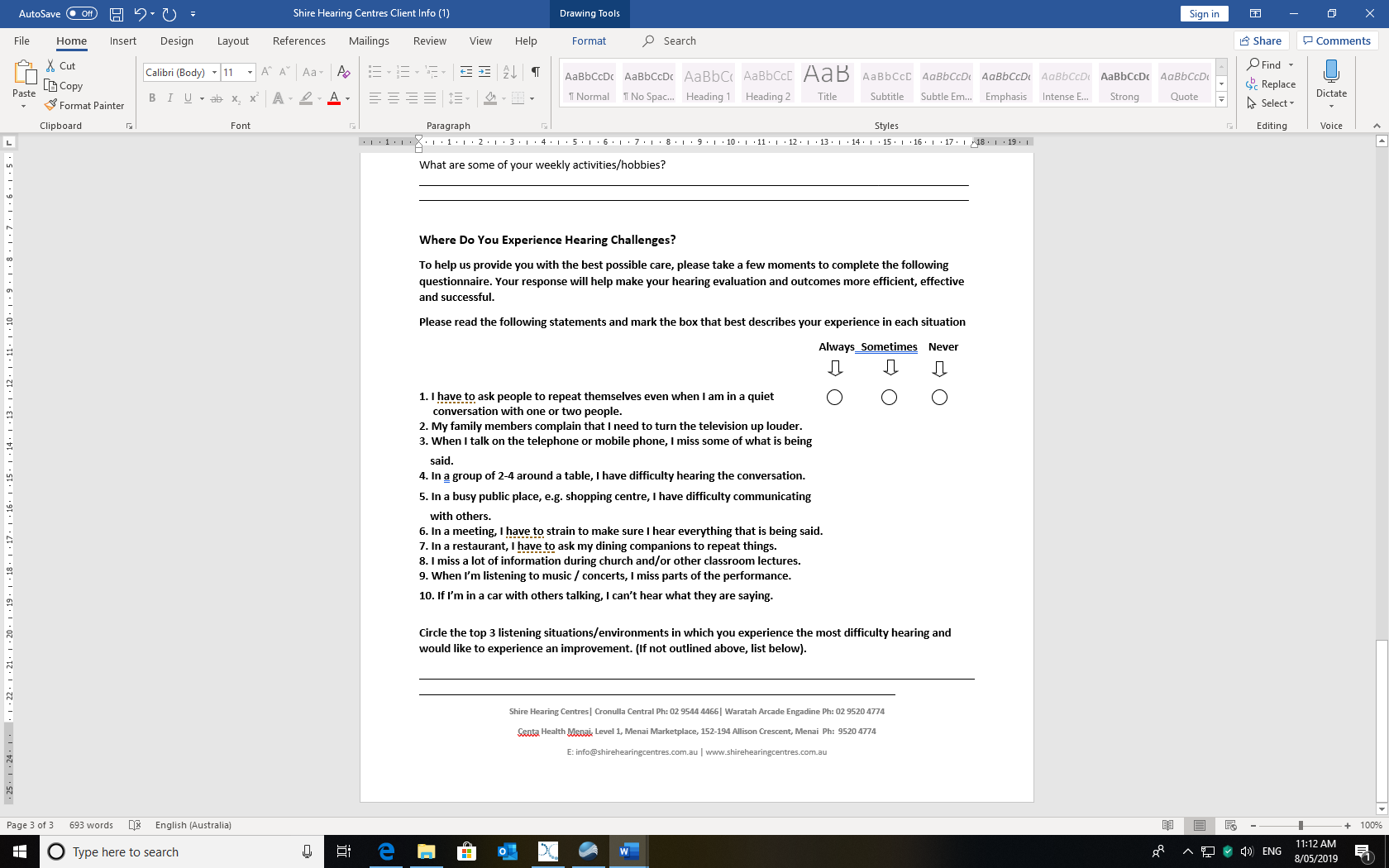
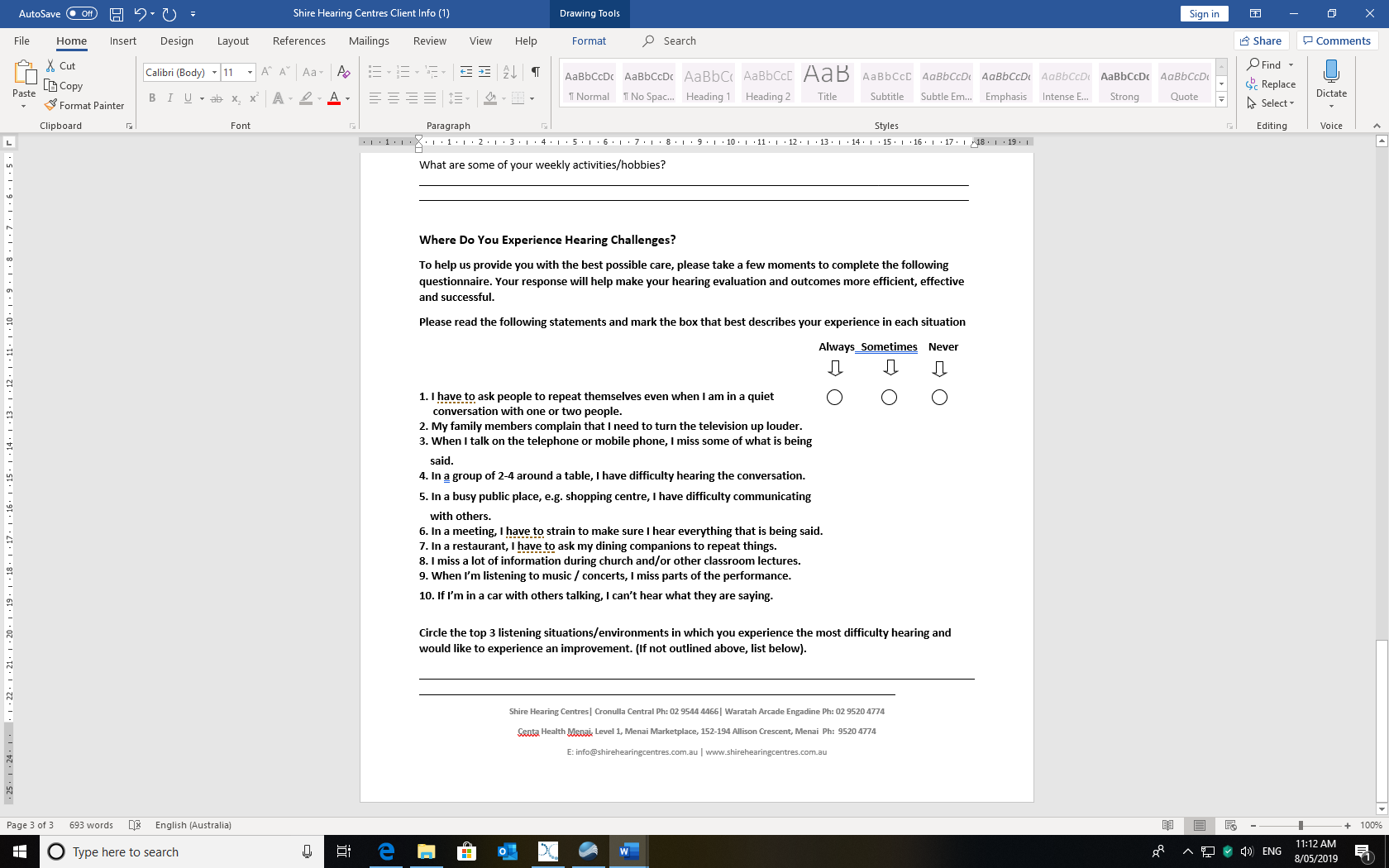
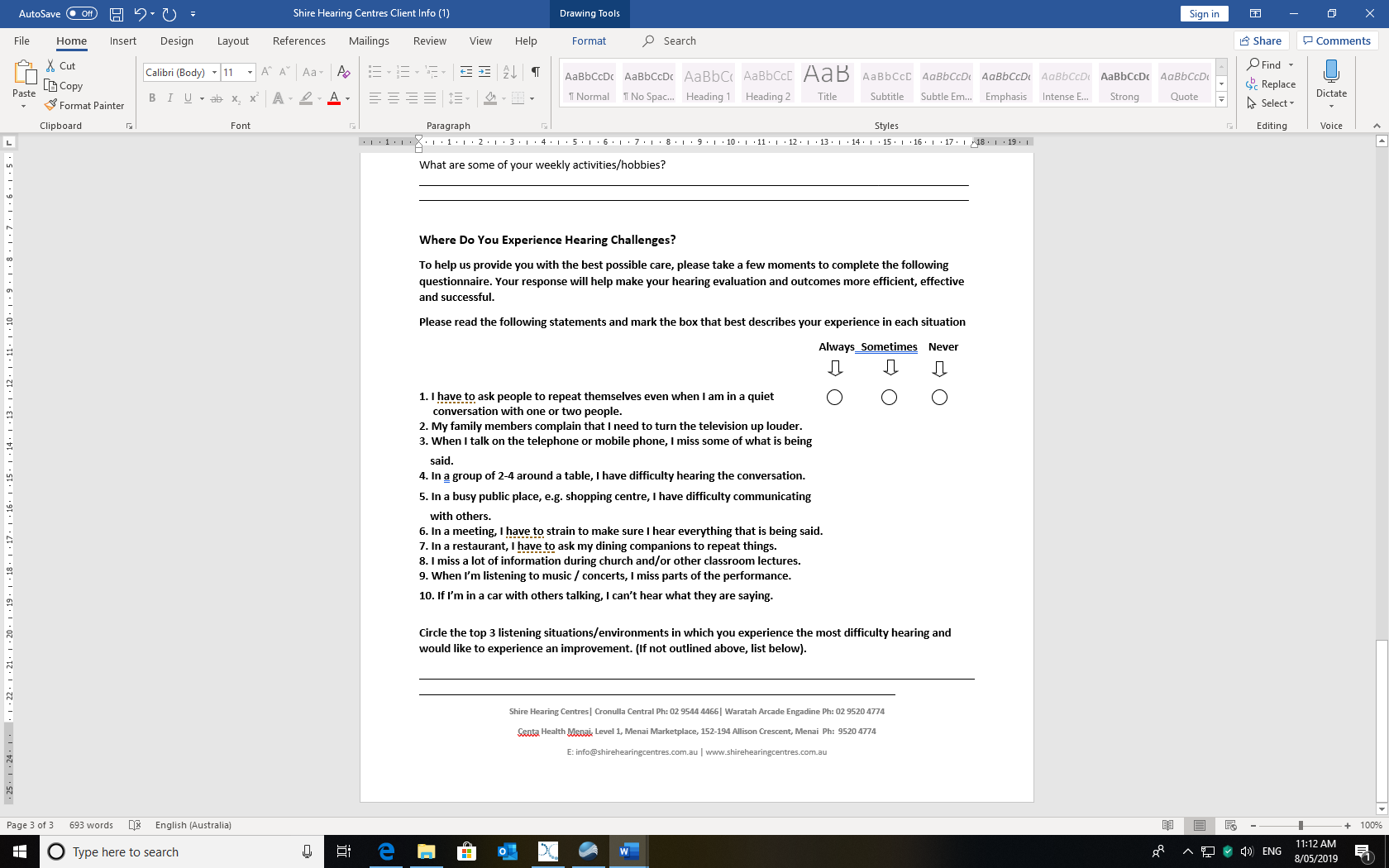
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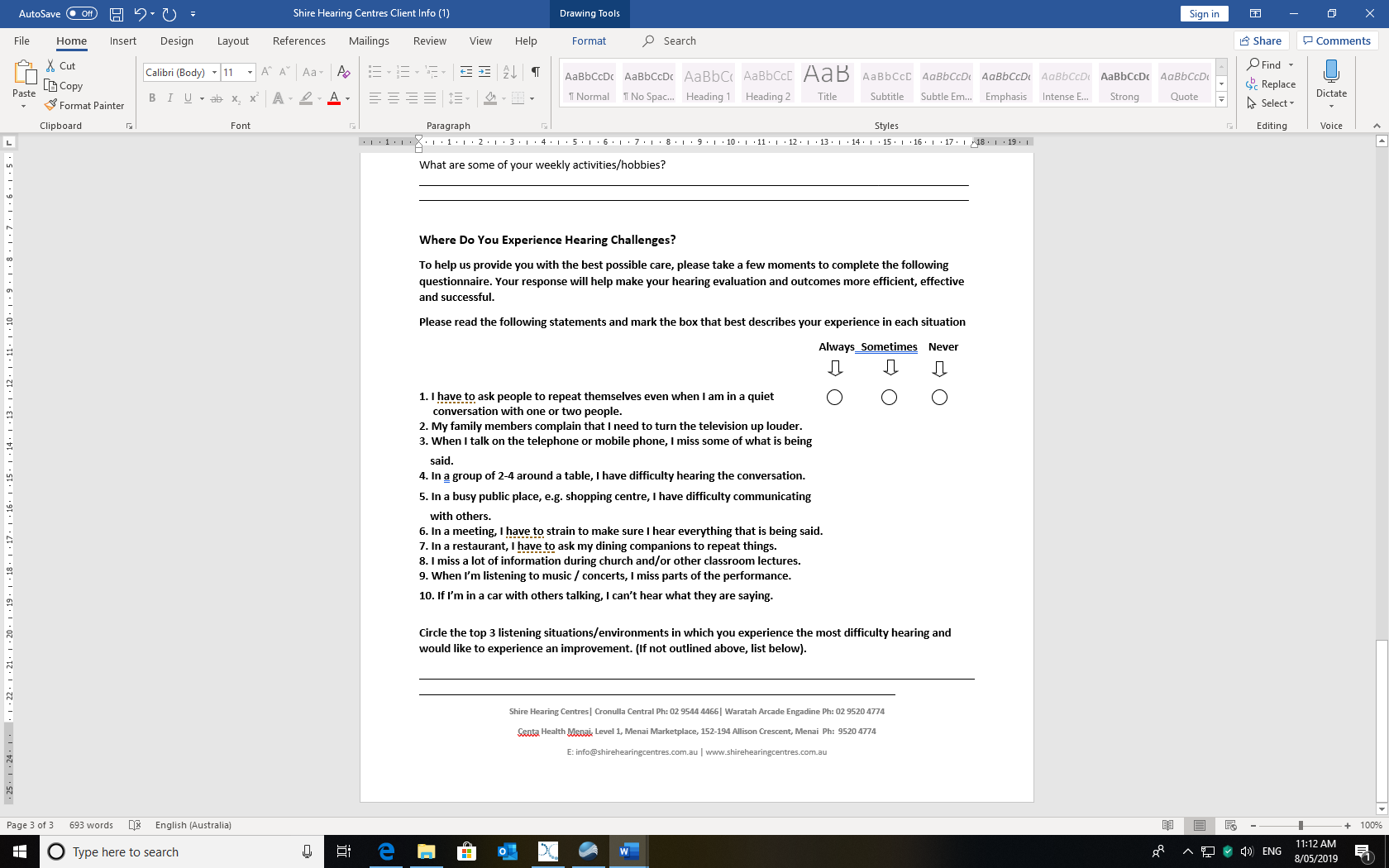
**Where Do You Experience Hearing Challenges?**

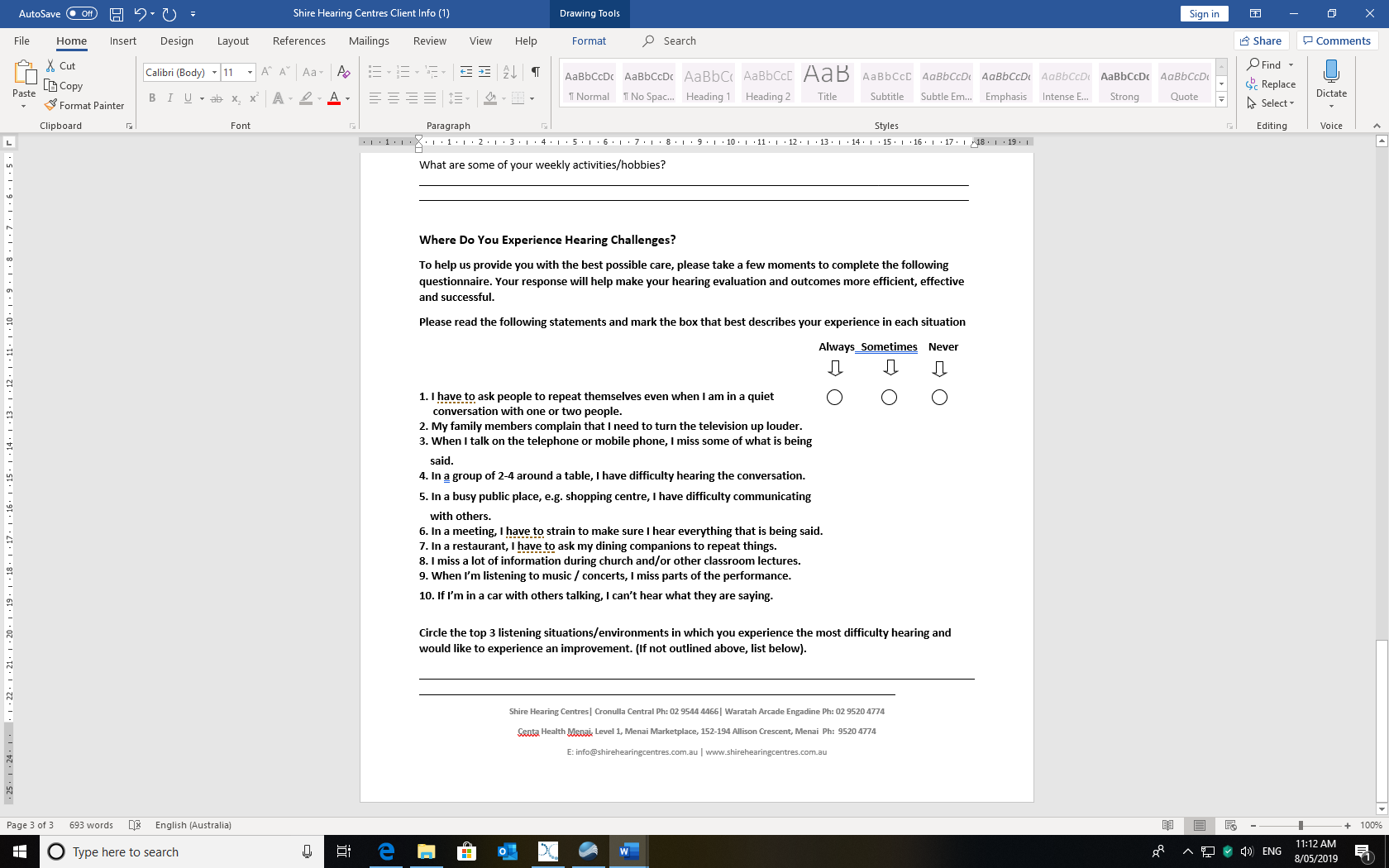
**To help us provide you with the best possible care, please take a few moments to complete the following questionnaire. Your response will help make your hearing evaluation and outcomes more efficient, effective and successful.**

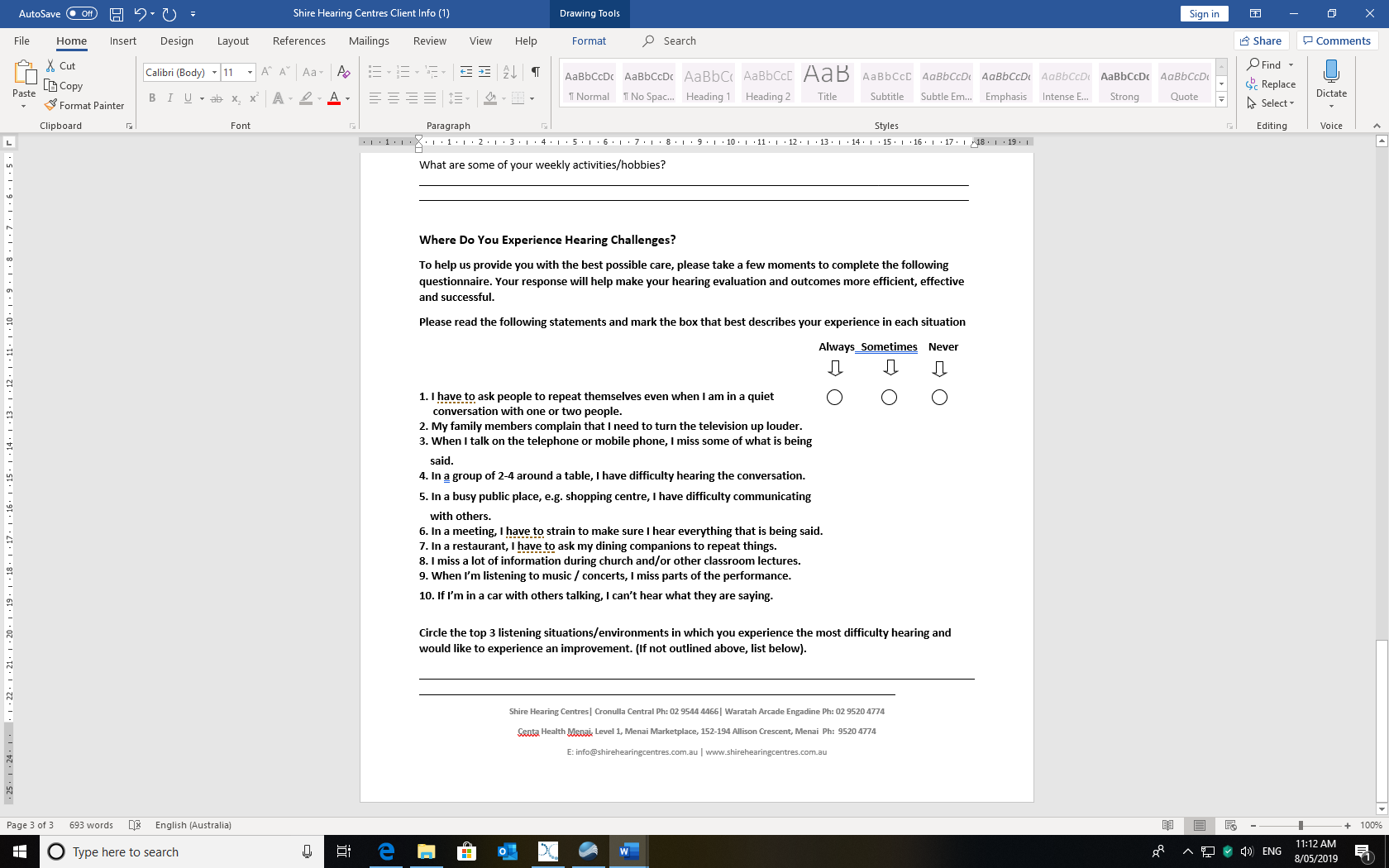
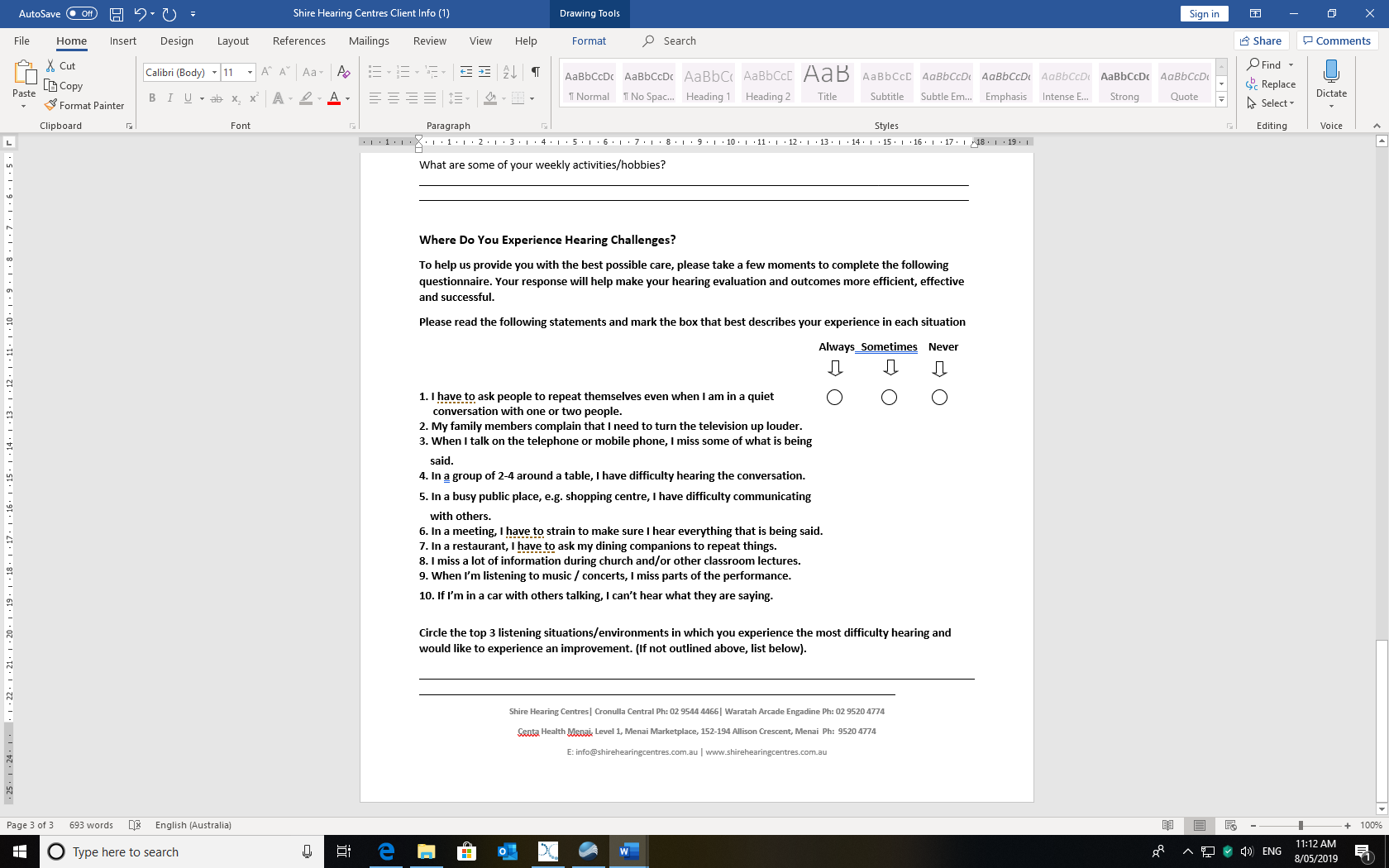
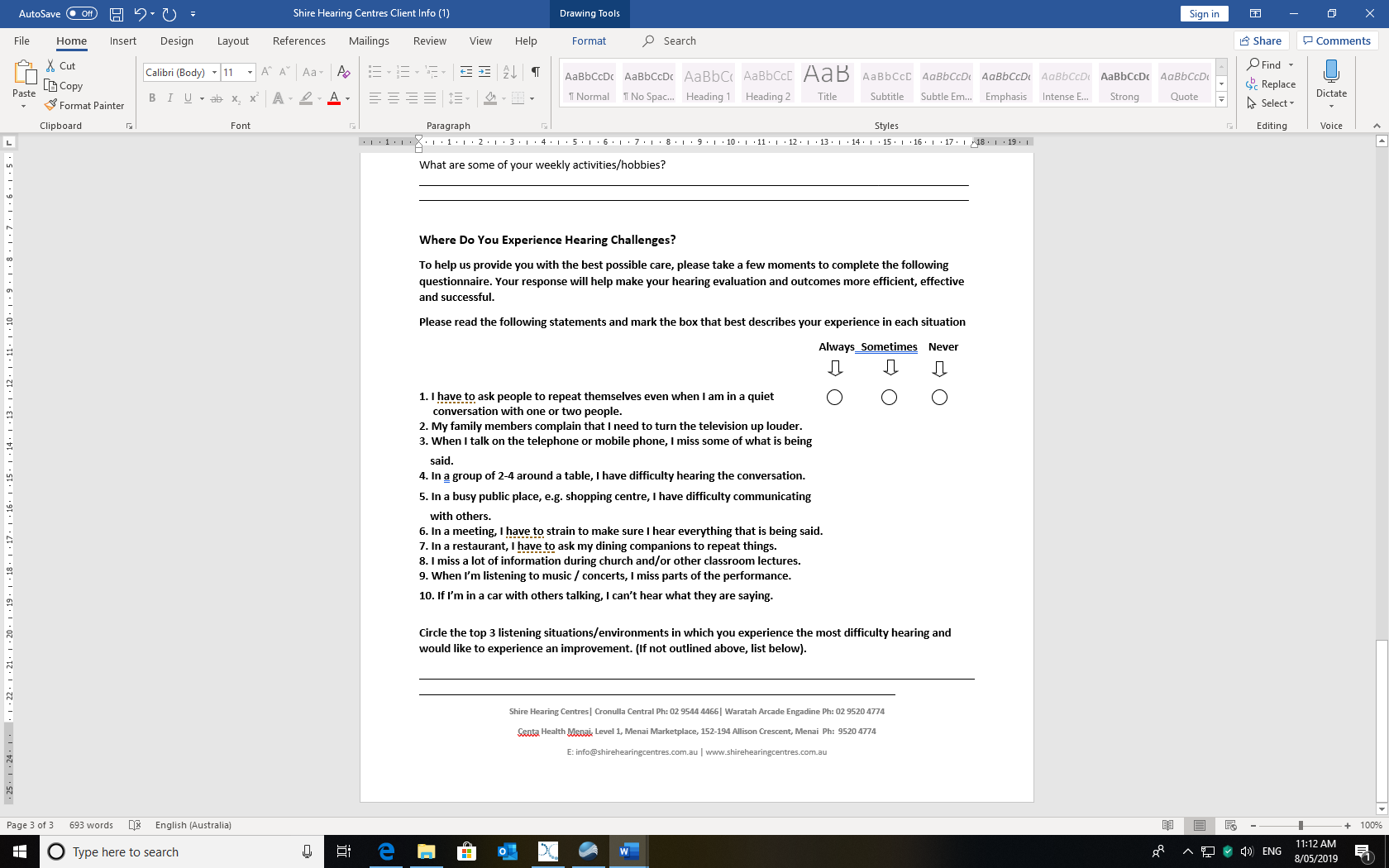
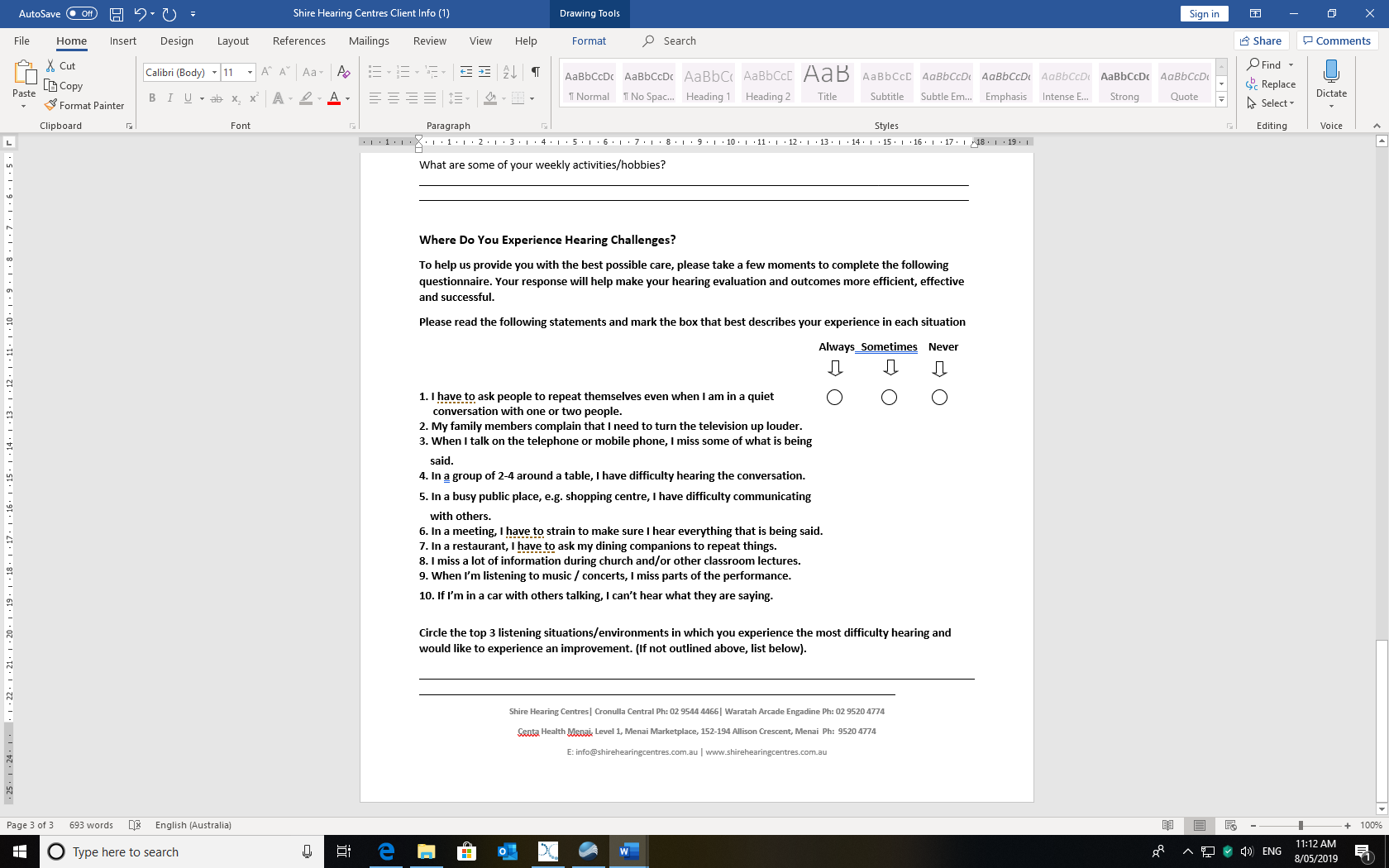
**Please read the following statements and mark the box that best describes your experience in each situation**

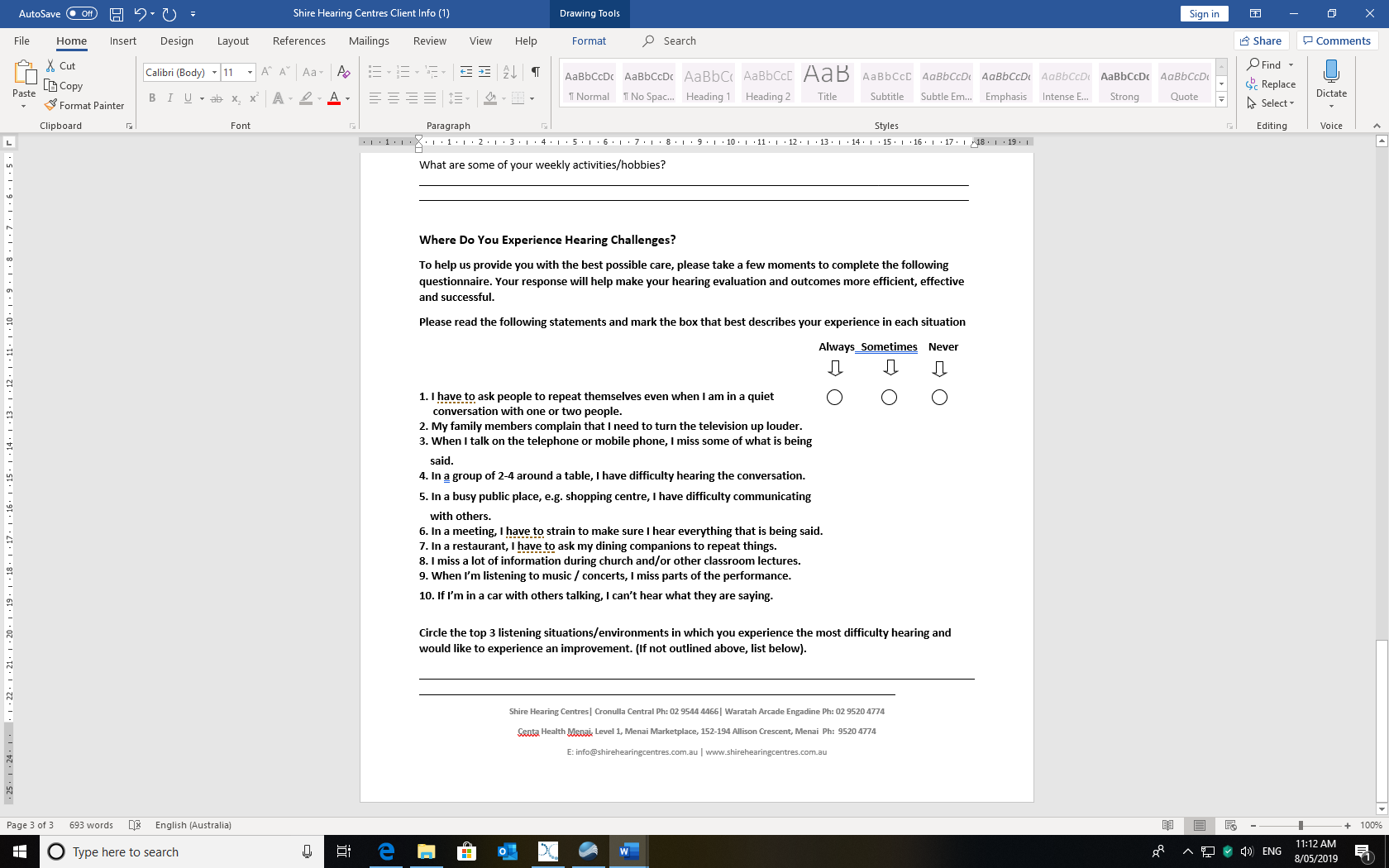
**Always Sometimes Never**

**1. I have to ask people to repeat themselves even when I am in a quiet   
 conversation with one or two people.  
2. My family members complain that I need to turn the television up louder.   
3. When I talk on the telephone or mobile phone, I miss some of what is being**

 **said.  
4. In a group of 2-4 around a table, I have difficulty hearing the conversation.**

**5. In a busy public place, e.g. shopping centre, I have difficulty communicating**

 **with others.  
6. In a meeting, I have to strain to make sure I hear everything that is being said.  
7. In a restaurant, I have to ask my dining companions to repeat things.**  **8. I miss a lot of information during church and/or other classroom lectures.**  **9. When I’m listening to music / concerts, I miss parts of the performance.**

**10. If I’m in a car with others talking, I can’t hear what they are saying.**