| **TINNITUS SAMPLE CASE HISTORY QUESTIONNAIRE (TSCHQ)** | |
|---|---|
| **NAME:** | **DATE:** |
| **DATE OF BIRTH:** | |

**1. Age:**

**2. Gender:** ☐ **Male** ☐ **Female**

**3. Handedness** ☐ **Right** ☐ **Left** ☐ **Both Sides**

**4. Family history of tinnitus complaints**

☐ **YES** **if YES:** ☐ **parents** ☐ **siblings** ☐ **children** ☐ **NO**

**5. Initial onset: When did you first experience your tinnitus?** _____

**6. How did you perceive the beginning?** ☐ **Gradual** ☐ **Abrupt**

**7. Was the initial onset of your tinnitus related to:**

☐ **loud blast of sound** ☐ **whiplash** ☐ **change in hearing** ☐ **stress**
☐ **head trauma** ☐ **others** _____

**8. Does your tinnitus seem to PULSATE ?**

☐ **YES with heart beat** ☐ **YES, different from heart beat** ☐ **NO**

**9. Where do you perceive your tinnitus**

☐ **right ear** ☐ **left ear** ☐ **both ears, worse in left** ☐ **both ears, worse in right**

☐ **both ears, equally** ☐ **inside the head** ☐ **elsewhere**

**10. How does your tinnitus manifest itself over time?**

☐ **intermittent** ☐ **constant**

**11. Does the *LOUDNESS* of the tinnitus vary from day to day?**

☐ **YES** ☐ **NO**

**12. Describe the *LOUDNESS* of your tinnitus using a scale from 1-100.**

**(1 = *VERY FAINT;* 100 = *VERY LOUD*)**

**_____ ( 1 – 100 )**

**13. Please describe in your own words what your tinnitus usually sounds like:**

_____

The following list gives examples of some possible sensations, feel free to use other terms as well: hissing, ringing, pulsing, buzzing, clicking, cracking, tonal (like a dial tone or other kinds of tones), humming, popping, roaring, rushing, typewriter, whistling, whooshing.

**14. Does your tinnitus more sound like a tone or more like noise:**

☐ **tone** ☐ **noise** ☐ **crickets** ☐ **other**

**15. Please describe the PITCH of your tinnitus:**

☐ very high frequency ☐ high frequency ☐ medium frequency ☐ low frequency

**16. What percent of your total awake time, over the last month, have you been aware of your tinnitus ? For example, 100% would indicate that you were aware of your tinnitus all the time, and 25% would indicate that you were aware of your tinnitus ¼ of the time**

_____ **% (Please write in a single number between 1 and 100.)**

**17. What percent of your total awake time, over the last month, have you been annoyed, distressed, or irritated of your tinnitus ?**

_____ **% (Please write in a single number between 1 and 100.)**

**18. How many different treatments have you undergone because of your tinnitus ?**

☐ none ☐ one ☐ several ☐ many

**19. Is your tinnitus reduced by music or by certain types of environmental sounds such as the noise of a waterfall or the noise of running water when you are standing in the shower ?**

☐ YES ☐ NO ☐ don't know

**20. Does the presence of loud noise make your tinnitus worse?**

☐ YES ☐ NO ☐ I don't know

**21. Does any head and neck movement (e.g. moving the jaw forward or clenching the teeth), or having your arms/hands or head touched, affect your tinnitus ?**

☐ YES ☐ NO

**22. Does taking a nap during the day affect your tinnitus?**

☐ worsens my tinnitus ☐ reduces my tinnitus ☐ has no effect

**23. Is there any relationship between sleep at night and your tinnitus during the day ?**

☐ YES ☐ NO ☐ I don't know

**24. Does stress influence your tinnitus?**

☐ worsens my tinnitus ☐ reduces my tinnitus ☐ has no effect

**25. Does medication have an effect on your tinnitus?**

| Medication | Effect / Details |
|---|---|
| | |
| | |
| | |
| | |

**26. Do you think you have a hearing problem?**

☐ YES ☐ NO

**27. Do you wear hearing aids?**

☐ Right ☐ Left ☐ Both ☐ None

**28. Do you have a problem tolerating sounds because they often seem much too loud ? That is, do you often find too loud or hurtful sounds which other people around you find quite comfortable ?**

☐ Never ☐ Rarely ☐ Sometimes ☐ Usually ☐ Always

**29. Do sounds cause you pain or physical discomfort ?**

☐ **YES** ☐ **NO** ☐ **I don't know**

**30. Do you suffer from headache?**

☐ **YES** ☐ **NO**

**31. Do you suffer from vertigo or dizziness?**

☐ **YES** ☐ **NO**

**32. Do you suffer from temporomandibular disorder?**

☐ **YES** ☐ **NO**

**33. Do you suffer from neck pain**

☐ **YES** ☐ **NO**

**34. Do you suffer from other pain syndromes?**

☐ **YES** ☐ **NO**

**35. Are you currently under treatment for psychiatric problems ?**

☐ **YES** ☐ **NO**