WICHITA STATE UNIVERSITY
COLLEGE OF HEALTH PROFESSIONS
Evelyn Hendren Cassat Speech-Language-Hearing Clinic

Audiology Adult Intake Questionnaire

IDENTIFYING INFORMATION

Patient full name: _____ Preferred Name: _____

Date of birth: _____ Age:_____ Social Security Number: _____ Race: _____

Biological Sex: Male ☐ Female ☐ Gender Identity: _____ Preferred Pronouns: _____

Phone (h): _____ (c): _____ Mobile carrier: _____ (w): _____

Email:_____ Address:_____

City: _____ State: _____ Zip: _____County:_____

Preferred method of communication: ☐Email ☐ Cell phone/text ☐ Home

Client primary language? _____ Race:_____

Is the patient employed? ☐ Yes ☐ No

Employment or previous employment, if retired? _____

Highest level of formal education: _____

If patient is unable to fill out the form, please fill out the following information:

Person completing this form: _____ Relationship to patient: _____

Date: _____ Phone Number: _____

FAMILY INFORMATION

Marital Status: _____

If married, what is the spouse's name: _____

Spouse's phone (h): _____ (c): _____ Moblie carrier: _____ (w): _____

Address:_____

City: _____ State: _____ Zip: _____County:_____

E-mail(s): _____

PRIMARY CARE PHYSICIAN

Primary Care Physician: _____Phone: _____

Address:_____

City: _____ State: _____ Zip: _____County:_____

EMERGENCY CONTACT

Primary Emergency Contact

Name: _____Relationship to the patient: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Secondary Emergency Contact

Name: _____Relationship to the patient: _____

Home phone: _____ Cell phone: _____ Work phone: _____

MEDICAL HISTORY

Does the patient have a medical diagnosis? ☐ Yes ☐ No

If yes, describe: _____

_____

The following questions are designed to help us evaluate your auditory system. Please answer them as accurately and completely as possible.

1. Why did you choose to schedule this appointment?

   _____

   _____
2. When did you first notice this problem?

   _____
3. Has this problem been changing suddenly or gradually?

   _____
4. Does it fluctuate? Please explain.

   _____
5. Which ear do you hear better out of? ☐ Right ☐ Left ☐ Same in Both
6. On a scale from 1 to 10 (1 being the worst and 10 being the best), how would you rate your overall hearing ability? _____
7. Has your hearing worsened in the past 72 hours? ☐ Yes ☐ No
8. Has your hearing worsened in the past 90 days? ☐ Yes ☐ No
9. Does Hearing Loss run in your family? ☐ Yes ☐ No

   If yes, please explain: _____
10. Have you been treated for ear infections as an adult? ☐ Yes ☐ No
11. Have you ever consulted an ear nose, and throat physician about your ears? ☐ Yes ☐ No

    If yes, please explain: _____
12. Have you ever had an ear surgery? ☐ Yes ☐ No

    If yes, please explain: _____
13. Are you aware of noises or ringing (tinnitus) in your ears or head? ☐ Yes ☐ No

    If yes, in which ear do you hear the noise/ringing? _____
14. I notice the noise/ringing: ☐ Occasionally ☐ Constantly
15. The noise/ringing is: ☐ not bothersome ☐ somewhat bothersome ☐ extremely bothersome

    Please describe what the noise/ringing sounds like: _____
16. Do you have any pain in your ears? ☐ Yes ☐ No
17. Do you feel a pressure or fullness sensation in either of your ears? ☐ Yes ☐ No

    If yes, please explain: _____

18. Have you ever been exposed to loud noises for any extended length of time? ☐ Yes ☐ No

    If yes, what was the source of the noise? ☐ Machinery ☐ Music ☐ Hunting ☐ Target Shooting

    ☐ Military ☐ Other:_____

    When exposed to noise did/do you wear ear protection? ☐ Yes ☐ No ☐ Sometimes

19. Do you have problems with dizziness? ☐ Yes ☐ No

    If yes, is your physician aware of your dizziness? ☐ Yes ☐ No

    Please describe your dizzy symptoms: _____

20. Do you have a pace maker or defibrillator? ☐ Yes ☐ No
21. Have you ever been diagnosed with any of the following conditions?

Condition:	Yes	No	If yes, please explain
Diabetes			
Heart Disease			
Severe Arthritis in Hands			
Strokes			
Migraines			
Dementia/ Alzheimer's			
Parkinson's			
Head Trauma			
HIV/AIDS			
Multiple Sclerosis			
Bell's Palsy			
Macular Degeneration			
High Blood Pressure			
Cancer			
Other			

22. Are you currently taking any medications? If yes, please list:

_____
_____
_____
_____
_____

Hearing Aid History

1. Do you currently wear hearing aids? ☐ Yes ☐ No

   If so, how long have you been wearing hearing aids? _____

2. How old are your current hearing aids? _____

3. Are you generally satisfied with your hearing aid? ☐ Yes ☐ No

   If no, please explain:

   _____

   _____

HHIE – Screening

Instructions: The purpose of this scale is to identify the problems your hearing loss may be causing you. Place a check mark below for each question. Do not skip a question if you avoid a situation because of your hearing problem. If you use a hearing aid, please answer the way you hear without the aid.

	Question	Yes	Sometimes	No
E-1	Does a hearing problem cause you to feel embarrassed when meeting new people?			
E-2	Does a hearing problem cause you to feel frustrated when talking to members of your family?			
S-3	Do you have difficulty hearing when someone speaks in a whisper?			
E-4	Do you feel handicapped by a hearing problem?			
S-5	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?			
S-6	Does a hearing problem cause you to attend religious services less often that you would like?			
E-7	Does a hearing problem cause you to have arguments with family members?			
S-8	Does a hearing problem cause you difficulty when listening to TV or radio?			
E-9	Does you feel that any difficulty with your hearing limits or hampers your personal or social life?			
S-10	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			

How did you hear about our clinic?

_____

_____

Please Stop Here

Office Use Only

Yes	_____x 4 =	_____
Sometimes	_____x 2 =	_____
No	_____x 0 =	_____
TOTAL		_____

0-8 = no difficulties
10 to 24 = mild to moderate
26 to 40 = severe

WICHITA STATE UNIVERSITY
COLLEGE OF HEALTH PROFESSIONS
Evelyn Hendren Cassat Speech-Language-Hearing Clinic

Financial Agreement:

The Wichita State University Evelyn Hendren Cassat Speech-Language-Hearing Clinic serves the community needs and University academic programs by providing a laboratory learning experience for graduate students. Services are provided by graduate students under the supervision of University faculty. As such, you will receive quality services while helping to facilitate the education of University students.

Payment is due at the time of service. If a client has insurance, the co-pay or out-of-pocket expense is due at the time of service. **Client with Medical Insurance:** We are an in-network provider for the following insurance companies- BCBS and Medicare. While we accept all private insurances, for those clients with out-of-network policies, payment is due in full at time of service. We will then file your claim and reimburse you for any charges your insurance company may pay. We do **not** bill Medicaid or KanCare.

Please Check the ONE box that applies:

☐ **Insurance:** If you have insurance and the insurance provider covers audiology services, as a convenience to you we will bill your insurance provider. You will be responsible for ANY unpaid amounts, including your co-pays, coinsurances, or deductibles. The clinic is not a Medicaid or KanCare provider, and will not bill services to them. Most insurances do not cover hearing aids, hearing aids will then be an out of pocket expense; you will be required to know if your insurance covers audiology services. The clinic will require a physician referral for all hearing evaluations. Please include a copy of your insurance card and photo ID for our records.

Primary Insurance		**Secondary Insurance**	
Insurance Company:		Insurance Company:	
ID Number:		ID Number:	
Group Number:		Group Number:	
Policy Holder's Name:		Policy Holder's Name:	
Policy Holder's Date of Birth:		Policy Holder's Date of Birth:	
Relationship to Policy Holder:		Relationship to Policy Holder:	

☐ **Private Pay:** If you do not have insurance or your insurance company will not pay for audiology evaluations. Most insurances do not cover hearing aids, hearing aids will then be an out of pocket expense; you will be required to know if your insurance covers audiology services.

Estimate of Payment: We provide a close estimate of patient out-of-pocket expenses. For any major expense, we highly recommend a pre-determination be submitted to your insurance company.

Delinquent Accounts: If a patient elects not to pay a debt in full or set up payment plan, the account will be turned over to collection agency, which will report your name to the credit bureau and supplementary communications may use pre-recorded voice or texting to cellular or wireless devices. Collection fees may be charged to your account, up to 33%. **Please note: as an institution of the State of Kansas, your name may be submitted to the Kansas Setoff Program, resulting in any debt owed to be collected from state income tax returns/refunds.**

By my signature below, I am indicating that I have read and fully understand and accept the Finanial Agreement at WSU Evelyn Hendran Cassat Speech Language Hearing Clinic and the guidelines presented above. I confirm that if I have insurance, I have provided the correct information above, and attached a copy of my insurance card. I confirm that if I don't have insurance or if insurance doesn't cover services at the WSU Evelyn Hendren Cassat Speech-Language-Hearing Clinic, I have provided accurate information WSU Evelyn Hendran Cassat Speech Language Hearing Clinic. I understand that this agreement will be reviewed every semester and that I may be denied services for the following semester if my account is delinquent at the close of a semester, and could be sent to collections for any delinquent amounts.

Signature of Client: _____ **Date:** _____
(or responsible party)

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PERMISSION FOR TEXT MESSAGES

I give permission for the Evelyn Hendren Cassat Speech Language Hearing Clinic to send me text messages for appointment reminders. I understand that message and data rates may apply, and that I may opt out by calling the clinic at 316-978-3289.

Patient Name: _____

Cell phone number: _____

Mobile phone carrier: _____

Signature: _____

WICHITA STATE UNIVERSITY

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PATIENT/CLIENT EMAIL CONSENT FORM

PLEASE READ CAREFULLY. THIS FORM DISCUSSES THE RISKS OF USING EMAIL TO SHARE PERSONAL HEALTH INFORMATION.

As a patient or client of a Wichita State University Clinic, you may request that we communicate with you via unencrypted electronic mail (email). This Fact Sheet will information of you the risks of communicating with your healthcare provider via email. Your health is important to us and we will make every effort to reasonably comply with your request to receive communications via email; however, we reserve the right to deny any request for email communications when it is determined that granting such a request would not be in your best interest.

WSU staff will make every effort to promptly respond to your requests for information via email; however, **IF YOU ARE EXPERIENCING AN EMERGENCY, YOU SHOULD NEVER RELY ON EMAIL COMMUNICATIONS AND SHOULD SEEK IMMEDIATE MEDICAL ATTENTION.**

Risks of using email to send protected health information include, but are not limited to:

- Email messages sent or received by WSU are generally not encrypted and may not be secure.
- Third parties may therefore be able to intercept, read, alter, forward or use personal health information transmitted by email, without authorization or detection by you or WSU.
- An unsecure email message may be accidentally or intentionally forwarded to unintended recipients.
- Employers and internet service providers generally have the right to inspect and review any email message transmitted, received, or stored using their systems.
- Information shared by email may be printed, copied, and stored by any recipient in multiple locations.
- Copies of email messages containing personal health information may be kept, for example on backup servers or hard drives, long after the "original" message is deleted by both the sender and the recipient.
- Documents may be forged, and identities may be stolen to take advantage of these vulnerabilities.
- Your personal health information in WSU's records may include information relating to prescriptions and medications, communicable diseases, physical impairments, chronic conditions, genetics, behavioral and mental health services, alcohol and drug abuse or addiction, billing and payments, and other information related to your medical care and condition.
- WSU is not responsible for any unauthorized access to or use of your personal health information that results from any unencrypted transmission that you authorize.

PERMISSION TO ALLOW COMMUNICATIONS BY UNENCRYPTED EMAIL

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into your medical record at the provider's discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means. By signing below, you agree to hold Wichita State University harmless for unauthorized use, disclosure, or access of your protection health information sent to the email address you provide.

Signature of Patient	Date
Printed Name of Patient	Email Address