Tinnitus and Hearing Survey

A. Tinnitus

	*No, **not** a problem*	*Yes, a **small** problem*	*Yes, a **moderate** problem*	*Yes, a **big** problem*	*Yes, a **very big** problem*
Over the last week, tinnitus kept me from sleeping.	0	1	2	3	4
Over the last week, tinnitus kept me from concentrating on reading.	0	1	2	3	4
Over the last week, tinnitus kept me from relaxing.	0	1	2	3	4
Over the last week, I couldn't get my mind off of my tinnitus.	0	1	2	3	4
	____	____	____	____	____
		Total of each column			

Grand Total ☐

B. Hearing

Over the last week, I couldn't understand what others were saying in noisy or crowded places.	0	1	2	3	4
Over the last week, I couldn't understand what people were saying on TV or in movies.	0	1	2	3	4
Over the last week, I couldn't understand people with soft voices.	0	1	2	3	4
Over the last week, I couldn't understand what was being said in group conversations.	0	1	2	3	4
	____	____	____	____	____
		Total of each column			

Grand Total ☐

C. Sound Tolerance

Over the last week, sounds were too loud or uncomfortable for me when they seemed normal to others around me.*	0	1	2	3	4

If you responded 1, 2, 3, or 4 to the statement above:

Please list two examples of sounds that are too loud or uncomfortable for you, but seem normal to others:

_____

_____

*If sounds are too loud for you while wearing hearing aids, please tell your audiologist.

For office use only (II): ☐M ☐H ☐NS ☐P ☐N

Instructions for Using the Tinnitus and Hearing Survey

Sections A and B

The four items in the **A (Tinnitus) subscale** describe common problems with tinnitus that are unrelated to hearing problems. The four items in the **B (Hearing) subscale** describe common hearing problems that would not be caused by tinnitus. Step-by-step instructions for using the THS to collaboratively determine if intervention for tinnitus is desirable and appropriate are provided below. **With the patient's filled-out THS in view:**

1. **Explain that intervention for tinnitus can help with the problems in Section A**
2. **Explain that intervention for tinnitus would not help with any of the problems listed in Section B**
3. **Describe what would be required to engage in the tinnitus intervention that is offered (logistics, cost, etc.)**
4. **Be available to answer questions or concerns about the tinnitus intervention that is offered, or about tinnitus in general**
5. **Allow the patient to decide whether or not to engage in the intervention**

Use of cut-off scores to determine candidacy for an intervention for tinnitus is strongly discouraged as it promotes decision making that does not take into account all of the factors in a patient's life. The most effective use of the THS is as a tool to quickly and efficiently separate hearing problems from tinnitus problems, which then allows the clinician to describe the available interventions relative to the specific problems the patient is experiencing. The patient can then decide if any of the interventions being offered are a good match for their lifestyle, and for problems they wish to address.

Section C

Sound tolerance problems are often reported by patients with tinnitus. The two items in the **C (Sound Tolerance) subscale** can be used to assist the clinician in developing an initial impression regarding the existence and type of sound tolerance problem. **Item 1** is used to screen for the existence of a sound tolerance problem. Any answer other than zero indicates some level of difficulty with tolerating sound.

Item 2 is intended to elicit examples from the patient (that the clinician will discuss with the patient) to: (1) ensure the patient really is experiencing a sound tolerance problem (and not something else); and (2) inform the clinician's opinion regarding the type of sound tolerance problem.

Examples for Item 2 that would suggest the patient **may not** have an abnormal reaction to sound include: (1) sounds that would be too loud for anyone (e.g., gunfire, nearby siren); (2) general annoyance to certain sounds that seem intrusive or that break concentration (e.g., background office noise, baby crying, dog barking, dentist drill, etc.); (3) complaints from hearing aid users who are only having trouble tolerating sounds that are commonly problematic for hearing aid users (e.g., silverware or dishes clanking, paper rustling).

After discussing the examples, if it appears the patient does have trouble tolerating sounds that most people can tolerate well, then the clinician will form an initial impression about whether the sound tolerance problem appears to be hyperacusis, misophonia, noise sensitivity, phonophobia, or some combination of these conditions. Use the definitions below to guide your impressions as you talk through the patient's examples.

Hyperacusis = physical discomfort caused by sound at levels that are comfortable for most people. With hyperacusis, all sounds are uncomfortable once they reach a certain loudness level, which varies from person to person with hyperacusis. The source of the sound is irrelevant—when *any* sound reaches a certain level, it is uncomfortably loud. Hyperacusis is almost always a bilateral condition. There is a strong association between hyperacusis and tinnitus.

Misophonia = emotional reactions to sound. With misophonia, it is not the loudness of a sound that causes discomfort (as is the case with hyperacusis). Rather, it is an emotional reaction to the sound that causes it to be experienced as uncomfortable. It is common for a person with misophonia to find particular sounds to be uncomfortable at a relatively low level, but to find other sounds at the same level to be acceptable. Trigger sounds most typically involve those made by the mouth or nose, such as chewing, breathing, lip-smacking, crunching, sniffing, coughing, and swallowing. Other sounds people make can trigger reactions, such as

repeated clicking of a ballpoint pen, typing, and foot tapping. Trigger sounds can include any sound in the environment that causes emotional reactions.

Noise sensitivity = general reactivity or discomfort (annoyance or feeling overwhelmed) due to a perceived noisy environment. Like misophonia, noise sensitivity is not driven by the intensity level or perceived loudness of sounds in the environment. People with noise sensitivity are typically most comfortable in a quiet environment. Noise sensitivity is highly prevalent in people who have experienced a traumatic brain injury (TBI). It is also associated with PTSD, depression, anxiety, and autism spectrum disorder.

Phonophobia = *fear* that a sound may occur that will result in discomfort, pain, or anxiety, or that will exacerbate an existing auditory disorder. Phonophobia does not pertain to negative *reactions* to sounds (as for hyperacusis, misophonia, and noise sensitivity), but rather the anticipatory *fear* that sound will be uncomfortable for any reason. Any of these sound tolerance conditions can cause a person to become phonophobic. People with phonophobia often do not want to venture outdoors because of the unpredictable nature of sounds in the outdoor environment. It would be common for a person with phonophobia to wear earplugs and/or earmuffs when outdoors (and indoors when away from the home).

"For office use only (**II**)" refers to **I**nterviewer's **I**mpressions as to whether/not the person has a sound toleranceproblem.

- **M** would be checked if **M**isophonia was suspected.
- **H** would be checked if **H**yperacusis was suspected.
- **NS** would be checked if **N**oise **S**ensitivity was suspected.
- **P** would be checked if **P**honophobia was suspected.
- If **N**one of these conditions is suspected, then **N** would be checked.
- It is OK to check more than one condition—any condition that is suspected should be checked.