



HYPERACUSIS/SOUND SENSITIVITY HISTORY QUESTIONNAIRE

Name: _____

Date: _____

MEDICAL HISTORY

- Please include any significant events, accidents, surgeries, ages when these occurred, or inherited conditions, congenital disorders, or family history related to auditory function.

- Current medications:

- Age of onset of symptoms, to best recollection. Please note memory/description of triggers.

- Any treatments tried for Sound Sensitivity:

- Effectiveness of the treatments:

TRIGGERS

- Worse Scenario Triggers: please list the main sounds that cause problems.
- Is there a particular person associated with the triggers?
- What have been the worst scenario incidents?
- List the reactions experienced or expressed (e.g. self harm, flight, verbal or bodily expressions of anger, frustration, rage, sorrow, confusion, or others):
- How long does it take to recover from the reactions?
- What are the activities or actions that can positively affect the reaction, either in the intensity or duration of the reaction?
- Best Case Scenario: What activities are the most comfortable for you? When are you happiest?

GENERAL INFORMATION

- Are earplugs used? If so how often? What type of earplugs? Ear muffs? Noise cancellation devices?
- Who lives in the home with you?
- What daily living activities are affected by the Sound Sensitivity? How does this impact the others in the household?
- Have you consulted medical providers? Please list.
- Do you have related conditions/behaviors/sensitivities? Please include any other sensory related issues.
- Is there any other information you would like us to know?