Neuromonics Tinnitus Treatment: Management Questionnaire

Name: Date Completed:

For Patient

Please complete the following to help you and the clinician understand the factors that will influence and shape your Neuromonics Tinnitus Treatment program.

Treatment Goals

When is the tinnitus most disturbing?
What activities are most impacted by the tinnitus?
List your desired treatment goals based on the above responses (see also the *Take Home Pack* for examples) • • •

Proposed Treatment Times

Nature of your work?
Regular daily activities?
Do you have many quiet periods?
Who lives at home?

Stress, Relaxation and Sleep

How stressful do you feel your lifestyle is?
What are the major sources of stress?
How do you try to manage your stress?
What types of exercise do you do?
How often do you exercise?
Do you have any difficulties falling asleep?
Do you feel you get a good nights rest?

Diet and medication

How many cups of coffee, tea or cola drinks do you usually consume per day?
How much alcohol do you generally drink?
Do you smoke and if so how much?
Does any medication you take seem to affect the tinnitus?

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