## Tinnitus Sample Case History Questionnaire (TSCHQ)

<table>
<thead>
<tr>
<th>NAME:</th>
<th>DATE:</th>
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<tbody>
<tr>
<td>DATE OF BIRTH:</td>
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### 1. Age: 

### 2. Gender:  
- [ ] Male  
- [ ] Female

### 3. Handedness  
- [ ] Right  
- [ ] Left  
- [ ] Both Sides

### 4. Family history of tinnitus complaints  
- [ ] YES  
- [ ] NO  
  - if YES:  
    - [ ] parents  
    - [ ] siblings  
    - [ ] children

### 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.

\[
(1 = \text{VERY FAINT}; 100 = \text{VERY LOUD})
\]

\[
\text{__________} \ (1 - 100)
\]

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
- [ ] I 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?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Effect / Details</th>
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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
<table>
<thead>
<tr>
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<th>Question</th>
<th>Options</th>
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<tbody>
<tr>
<td>29</td>
<td>Do sounds cause you pain or physical discomfort?</td>
<td>YES, NO, I don’t know</td>
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<tr>
<td>30</td>
<td>Do you suffer from headache?</td>
<td>YES, NO</td>
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<tr>
<td>31</td>
<td>Do you suffer from vertigo or dizziness?</td>
<td>YES, NO</td>
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<tr>
<td>32</td>
<td>Do you suffer from temporomandibular disorder?</td>
<td>YES, NO</td>
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<tr>
<td>33</td>
<td>Do you suffer from neck pain</td>
<td>YES, NO</td>
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<tr>
<td>34</td>
<td>Do you suffer from other pain syndromes?</td>
<td>YES, NO</td>
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<tr>
<td>35</td>
<td>Are you currently under treatment for psychiatric problems?</td>
<td>YES, NO</td>
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