Thrive
HEARING & TINNITUS SOLUTIONS

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# Tinnitus Assessment

Patient Name _____ Date _____

## How does Tinnitus affect you and how often?

## How does Tinnitus affect your family?

## Do you feel Tinnitus interferes with your ability to understand conversations?

## Are there places/activities you avoid because the situation is too loud?

## What are your goals for Tinnitus treatment?

## If you didn't have Tinnitus, how would life be different?