

# Client history



<b>Client:</b>	<b>D.O.B.:</b>	<b>Clinician:</b>	<b>Date:</b>	<b>Voucher Number:</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

HSP    New    Return    Private    Workcover   GP    MF

## Presenting symptoms/complaints:

Onset:    Gradual    Sudden    Recent    Fluctuating    Other   How long: \_\_\_\_\_

Communication difficulties:    TV    1:1    Car    Phone    Bgn    Socialising

Hearing aid history:   Model/type   **L**   **R**    Never aided

Provider: \_\_\_\_\_ Date fitted: \_\_\_\_\_

Current issues with hearing aids:

## General health:

**L**   **R**

Infections/discharge

Tinnitus

Surgery/ENT

Yes    No   Noise exposure

Yes    No   Vertigo/balance

Yes    No   Family history

Good general health    Vision problems    Dexterity issues    Memory problems

Changing living/social environment    Living alone    Lives in nursing home    Lives with family

Other notes:

**Results:**    Explained to client   R PTA \_\_\_\_\_   L PTA \_\_\_\_\_

Otoscopic exam:   **L**   **R**

Pure tone audiometry:    Stable    Changed   Comments: \_\_\_\_\_

Speech audiometry:    Consistent with audiogram   Comments: \_\_\_\_\_

Immittance audiometry (Tymp/Acoustic reflexes):   **L**   **R**

COSI established and completed    Current aids adequate    Minimal HL criteria met

Refit form completed Auto refit   Reason: \_\_\_\_\_

Rehabilitation/Recommendations:

**Action:**   Claim    600    800    610    810    Report to GP    Medical clearance required    Complex client referral

**Next appointment:**    Fit    Review/adjustment    IMP/Discussion