Sound Therapy Baseline Profile

Please complete before you begin listening

Client Name: ____

Date: ___________ Occupation: ____________________________ Gender: M/F Age:______

Date commenced program:______ Months on program:_____ Est. hours listened to date:____

	Condition before Sound Therapy Please circle a number from 1 to 5 for conditions relevant to you.	**Comments -** Please describe briefly how this condition affects you. This will enable your consultant to evaluate any changes in your progress after Sound Therapy. **If not applicable to you write "NA"**
Sleep	Bad Poor Fair Good Great 1 2 3 4 5	
Energy/ fatigue	1 2 3 4 5	
Stress/ Anxiety level	1 2 3 4 5	
Tinnitus	1 2 3 4 5	
Hearing	1 2 3 4 5	
Balance/ dizziness	1 2 3 4 5	
Blocked ear/fullness	1 2 3 4 5	
CPS **Ability to hear over background noise**	1 2 3 4 5	
Sound sensitivity	1 2 3 4 5	
Well Being	1 2 3 4 5	
Depression	1 2 3 4 5	
Confidence	1 2 3 4 5	
Anger/ moodiness	1 2 3 4 5	
Memory / Concentration	1 2 3 4 5	
Blood pressure	1 2 3 4 5	
Speech/ Communication	1 2 3 4 5	
Headaches	1 2 3 4 5	
Music/singing ability	1 2 3 4 5	

Please see over...

Your health history

Condition for which you are seeking therapy?	What do you believe caused the condition?	How long you have had the condition?

What was your score on the personal listening routine assessment? ________ (See Workbook)
Which group does that put you in? Sensitive ___ Moderate ___ Fully Fit ___

*** Questions below apply to those seeking treatment for tinnitus only.**

If you have any of the following conditions please describe them…

Do you have any of the following?		Description	How long
Tinnitus	**Y/N**		
High level of hearing loss in one ear	**Y/N**		
Are you a highly distressed person	**Y/N**		
Multitone tinnitus	**Y/N**		
Pulsatile tinnitus	**Y/N**		
Does your tinnitus get worse when you're exposed to moderately loud sound	**Y/N**		
Are you pursuing compensation your tinnitus	**Y/N**		
Meniere's disease	**Y/N**		
Are you regularly exposed to loud noise without adequate hearing protection	**Y/N**		
Have you ever had an injury to the ear or head?	**Y/N**		
Have you ever had surgery to the ear or head?	**Y/N**		
Do you ever experience dizziness or loss of balance?	**Y/N**		
Do you suffer from hyperacusis or over sensitivity to sound?	**Y/N**		
Do you suffer from hearing loss?	**Y/N**		
Do you experience blocked or fullness of the ear?	**Y/N**		
Are you on any medications?	**Y/N**		
Do you experience neck or jaw tension?	**Y/N**		
Have you experienced repeated ear infections requiring treatment?	**Y/N**		
Do you have chemical sensitivity?	**Y/N**		

Comments:

Thank you for taking the time to complete this Baseline Summary. So that we can monitor your progress, please return this page to your Sound Therapy SYNERGY Consultant.