Sound Therapy

Progress Summary Sheet

To be completed after 3 months on your listening program

Client Name: _____ Date: _____

Occupation: _____ Gender: M/F Age _____

Date commenced program:___ Months on program:___ Est. hours listened to date ___

- Reasons for starting Sound Therapy? (Please list the conditions that prompted you to try the program, i.e. tinnitus, hearing loss, blocked ear, etc.)

  _____

  _____

- What do you believe caused this condition/s? (ie, noise, virus, medication, stress, injury etc…)

  _____

  _____

- Have you noticed any other changes or benefits? (Please use more pages if required)

  _____

  _____

- Have there been any comments by others about noticeable changes (partner, friend, practitioner etc)

  _____

  _____

- Have there been any other treatments or factors which may have contributed to your results? (change of medications etc)

  _____

  _____

	Condition before Sound Therapy	**Condition after 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	Bad Poor Fair Good Great 1 2 3 4 5	
Energy/ fatigue	1 2 3 4 5	1 2 3 4 5	
Stress/ Anxiety level	1 2 3 4 5	1 2 3 4 5	
Tinnitus	1 2 3 4 5	1 2 3 4 5	
Hearing	1 2 3 4 5	1 2 3 4 5	
Balance/ dizziness	1 2 3 4 5	1 2 3 4 5	
Blocked ear/fullness	1 2 3 4 5	1 2 3 4 5	
CPS Ability to hear over background noise	1 2 3 4 5	1 2 3 4 5	
Sound sensitivity	1 2 3 4 5	1 2 3 4 5	
Well Being	1 2 3 4 5	1 2 3 4 5	
Depression	1 2 3 4 5	1 2 3 4 5	
Confidence	1 2 3 4 5	1 2 3 4 5	
Anger/ moodiness	1 2 3 4 5	1 2 3 4 5	
Memory / Concentration	1 2 3 4 5	1 2 3 4 5	
Blood pressure	1 2 3 4 5	1 2 3 4 5	
Speech/ Communication	1 2 3 4 5	1 2 3 4 5	
Headaches	1 2 3 4 5	1 2 3 4 5	
Music/singing ability	1 2 3 4 5	1 2 3 4 5	
Other specify	Bad Poor Fair Good Great 1 2 3 4 5	Bad Poor Fair Good Great 1 2 3 4 5	

- **Can we use your comments in our promotional materials? Y / N**
- **If so, do you consent to us using your real name? Y / N**

Please return this page to your Sound Therapy SYNERGY Consultant to assist our research.