

# CLIENT REGISTRATION FORM



(Please provide a printed copy to the clinic)

Title: Mr / Mrs / Ms / Miss (please circle one)

Home Phone:

Full Name:

Mobile:

Date of Birth: / /

Email:

Address:

Name & Address of Doctor:

Post Code:

• Are you receiving Pensioner Health Benefits? Yes / No

If yes, what is your CRN number? (on pension card)

• National Insurance & Disability Scheme (NDIS) Yes / No

• Home Care Package Yes / No

• Are you a Veterans' Affairs cardholder? Yes / No

If yes, what is your number and type of card?

No. Gold / White

• Where did you hear about Hearing Professionals?

Doctor  Workplace  Newspaper  ENT/Specialist

Newsletter  Hearing Professionals Website

Property Signage  Mailout/Flyer  Google

Family/Friend  Facebook  Commonwealth HSP/DVA

Email Newsletter  SMS Message

• Are you eligible for funding from any of the following schemes for your hearing?

Workcover/Workplace compensation Yes / No

If yes, in what year:

Employer Name:

Other

• Would you like to receive our Newsletter? Yes / No

## HEARING HEALTH HISTORY

Please circle all answers that apply

1. How long have you had difficulty hearing? \_\_\_\_\_

2. Have you had your hearing tested in the past? Yes / No

If yes, what was the result? \_\_\_\_\_

When have you last seen an audiologist/hearing care provider? \_\_\_\_\_

3. Have you ever been exposed to loud noise? Yes / No

If yes, please tick what source;  Musician

Work/Industry Related  Shooting/Firearms

Other \_\_\_\_\_

How many years total do you estimate your exposure to loud noise? \_\_\_\_\_ months / years

4. Have you worn a hearing aid before? Yes / No

If yes, please state: **Quantity:**  1 or  2

**Type:**  Behind the Ear  In the Canal  In the Ear

5. Do you have a family history of hearing loss? Yes / No

If yes, please state:  Mother  Father  Brother  Sister

Other Relatives \_\_\_\_\_

6. Have you ever seen an Ear, Nose and Throat Specialist?

If yes, please state the name & address Yes / No

Please turn over and complete the reverse side

# HEARING HEALTH HISTORY

7. Have you had ear surgery? Yes / No

If yes, provide details

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8. Do you have arthritis in your hands or any other condition that might affect the use of a hearing aid?

If yes, please explain Yes / No

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9. Do you take Blood Thinners? Yes / No

10. Do you experience any of the following in regards to your ears?

Pain / Discomfort	Yes / No	Left / Right
Discharge / Infection	Yes / No	Left / Right
Dizziness / Vertigo	Yes / No	
Numbness in the face	Yes / No	Left / Right
Sudden hearing loss	Yes / No	Left / Right
Fluctuating Hearing Loss	Yes / No	Left / Right
Ringing / Buzzing	Yes / No	Left / Right
Hole in eardrum?	Yes / No	Left / Right

11. Do you have?	Diabetes	Yes / No
	HIV or AIDS	Yes / No
	Haemophilia	Yes / No
	Hepatitis	Yes / No

# HEARING AND COMMUNICATION QUESTIONNAIRE

1. What statement do you feel fits best to describe your view in regards to your hearing ability?

- I do not have a problem with my hearing
- I don't think I have a hearing loss
- I think I need help with my hearing
- I would like to do something about my hearing loss

2. On a scale of 1 to 10, 1 being the worst and 10 being the best, how would you rate your hearing ability?

1   2   3   4   5   6   7   8   9   10

3. On a scale of 1 to 10, 1 being not very important and 10 being very important, how important is it for you to improve your hearing right now?

1   2   3   4   5   6   7   8   9   10

**If you have scored 3 or less for the last question, please do not complete the rest of this questionnaire.**

4. Please complete the top three situations where you would most like to hear better. *Be as specific as possible.*

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5. Which situations do you feel you struggle to hear well or clearly – *please check the following boxes that apply*

- 1v1 conversation     Watching TV
- Softly spoken people     Small groups (2-4 people)
- Larger groups (4+ people)     Meetings/Clubs
- Mildly noisy situations (e.g TV in the background)
- Very noisy situations (e.g Restaurants/parties)
- When people are facing away/at a distance
- Family gatherings     Workplace     Music
- Outside     Hall/large spaces
- Phone calls/streaming

**THANK YOU FOR ANSWERING THE QUESTIONS.  
YOUR RESPONSES WILL ASSIST US IN PROVIDING YOU WITH THE BEST HEARING HEALTHCARE**

# MEDICAL INFORMATION AND PRIVACY CONSENT FORM

During the course of your interactions with Hearing Professionals (HP), you will be required to disclose personal information. This personal information is required to assist us to manage your hearing health. Your personal information is protected by law, including the Privacy Act 1988 (Cth).

By signing below, I understand and provide consent to the following uses and disclosures of personal information;

- Personal information may be provided to third parties who have a direct interest in your hearing health, such as Doctors, Specialists and other Hearing Service Providers. Personal information may also be provided to (and stored by) third parties in order for us to obtain approval or vouchers from State or Commonwealth Government Agencies, such as the Office of Hearing Services or WorkSafe Victoria. The transfer of personal information to these third parties can be made by secure electronic communications or by normal Australia Post.
- Should your personal information be withheld, this may result in our inability to provide hearing services to you. For example under the Office of Hearing Services Program.
- By providing my personal information, HP can contact me by phone, email, SMS, or post information relating to my hearing health and related services.
- Personal information (hardcopy and electronic) will be stored by HP in a secure environment based in Australia.
- Personal information will not be disclosed to third parties outside of Australia, unless specifically requested by you.
- Requests for copies, complaints or alterations relating to your personal information can be made by visiting our Privacy Policy on our website at [www.hearingpro.com.au](http://www.hearingpro.com.au).

**I understand that if medical advice is needed that I should see my Medical Practitioner.**

I understand that:

- Cerumen (ear wax) removal;
- Lyric fitting, removal and refitting;
- And/or Impression taking;

Involve minor risks such as small abrasions or minor bleeding.

In the event of uncommon abrasion or trauma, I will be referred to my GP or ENT for treatment. I have notified the Audiologist/Audiometrist, now present, in my complete Hearing Health History Form, of any medications or conditions that could impact this procedure.

Signature

Date

Client Name

