Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | Sometimes | No |
| 1. Because of your tinnitus, is it difficult for you to concentrate? |  |  |  |
| 1. Does the loudness of your tinnitus make it difficult to hear people? |  |  |  |
| 1. Does your tinnitus make you angry? |  |  |  |
| 1. Does your tinnitus make you confused? |  |  |  |
| 1. Because of your tinnitus, do you feel desperate? |  |  |  |
| 1. Do you complain a great deal about your tinnitus? |  |  |  |
| 1. Because of your tinnitus, do you have trouble falling asleep? |  |  |  |
| 1. Do you feel as though you cannot escape your tinnitus? |  |  |  |
| 1. Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner/movies)? |  |  |  |
| 1. Because of your tinnitus, do you feel frustrated? |  |  |  |
| 1. Because of your tinnitus, do you feel you have a terrible disease? |  |  |  |
| 1. Does your tinnitus make it difficulty for you to enjoy life? |  |  |  |
| 1. Does your tinnitus interfere with your job or household responsibilities? |  |  |  |
| 1. Because of your tinnitus, do you find you are often irritable? |  |  |  |
| 1. Because of your tinnitus, is it difficult for you to read? |  |  |  |
| 1. Does your tinnitus make you upset? |  |  |  |
| 1. Do you feel that your tinnitus has placed stress on your relationships? |  |  |  |
| 1. Do you find it difficult to focus your attention away from your tinnitus and on other things? |  |  |  |
| 1. Do you feel you have no control over your tinnitus? |  |  |  |
| 1. Because of your tinnitus, do you often feel tired? |  |  |  |
| 1. Because of your tinnitus, do you feel depressed? |  |  |  |
| 1. Does your tinnitus make you feel anxious? |  |  |  |
| 1. Do you feel that you can no longer cope with your tinnitus? |  |  |  |
| 1. Does your tinnitus get worse when you are under stress? |  |  |  |
| 1. Does your tinnitus make you feel insecure? |  |  |  |

To be completed by clinician Totals: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

THI Score: (number of “yes” x 4) (number of “sometimes x2) = Total Score: \_\_\_\_\_\_\_\_\_

0-16 Slight (Only heard in quiet environments)

18-36 Mild (Easily masked by environmental sounds and activities)

38-56 Moderate ( Noticed in the presence of background noise, although activities can still be performed)

58-76 Severe (Almost always heard, leads to disturbed sleep patterns and can interfere with daily activities)

78 – 100 Catastrophic (Always heard, disturbed sleep patterns, difficulty with any activities)