Name: ____________________________ Date: __________

MISOPHONIA ASSESSMENT QUESTIONNAIRE (MAQ)

If a parent or caregiver, please answer for the child as best you are able, or substitute the words, "I feel that my child's sound issues" for the words "my sound issues".

RATING SCALE: 0 = not at all, 1 = a little of the time, 2 = a good deal of the time, 3 = almost all the time	0	1	2	3
1. My sound issues currently make me unhappy	○	○	○	○
2. My sound issues currently create problems for me.	○	○	○	○
3. My sound issues have recently made me feel angry.	○	○	○	○
4. I feel that no one understands my problems with certain sounds.	○	○	○	○
5. My sound issues do not seem to have a known cause.	○	○	○	○
6. My sound issues currently make me feel helpless.	○	○	○	○
7. My sound issues currently interfere with my social life.	○	○	○	○
8. My sound issues currently make me feel isolated.	○	○	○	○
9. My sound issues have recently created problems for me in groups.	○	○	○	○
10. My sound issues negatively affect my work/school life (currently or recently).	○	○	○	○
11. My sound issues currently make me feel frustrated.	○	○	○	○
12. My sound issues currently impact my entire life negatively.	○	○	○	○
13. My sound issues have recently made me feel guilty.	○	○	○	○
14. My sound issues are classified as 'crazy'.	○	○	○	○
15. I feel that no one can help me with my sound issues.	○	○	○	○
16. My sound issues currently make me feel hopeless.	○	○	○	○
17. I feel that my sound issues will only get worse with time.	○	○	○	○
18. My sound issues currently impact my family relationships.	○	○	○	○
19. My sound issues have recently affected my ability to be with other people.	○	○	○	○
20. My sound issues have not been recognized as legitimate.	○	○	○	○
21. I am worried that my whole life will be affected by sound issues.	○	○	○	○

By Marsha Johnson, revised by Tom Dozier

Revised 07/20/13

Tinnitus Handicap Inventory (THI)

This form is for informational purposes only and should not take the place of consultation and evaluation by a healthcare professional.

Your Name: ______________________ Date: ______________

Instructions: The purpose of this questionnaire is to identify, quantify, and evaluate the difficulties that you may be experiencing because of tinnitus. Please do not skip any questions. When you have answer all the questions, add up your total score, based on the values for each response.

Question			
1. Because of your tinnitus, is it difficult for you to concentrate?	Yes (4)	Sometimes (2)	No (0)
2. Does the loudness of your tinnitus make it difficult for you to hear people?	Yes (4)	Sometimes (2)	No (0)
3. Does your tinnitus make you angry?	Yes (4)	Sometimes (2)	No (0)
4. Does your tinnitus make you feel confused?	Yes (4)	Sometimes (2)	No (0)
5. Because of your tinnitus, do you feel desperate?	Yes (4)	Sometimes (2)	No (0)
6. Do you complain a great deal about your tinnitus?	Yes (4)	Sometimes (2)	No (0)
7. Because of your tinnitus, do you have trouble falling to sleep at night?	Yes (4)	Sometimes (2)	No (0)
8. Do you feel as though you cannot escape your tinnitus?	Yes (4)	Sometimes (2)	No (0)
9. Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies)?	Yes (4)	Sometimes (2)	No (0)
10. Because of your tinnitus, do you feel frustrated?	Yes (4)	Sometimes (2)	No (0)
11. Because of your tinnitus, do you feel that you have a terrible disease?	Yes (4)	Sometimes (2)	No (0)
12. Does your tinnitus make it difficult for you to enjoy life?	Yes (4)	Sometimes (2)	No (0)
13. Does your tinnitus interfere with your job or household responsibilities?	Yes (4)	Sometimes (2)	No (0)
14. Because of your tinnitus, do you find that you are often irritable?	Yes (4)	Sometimes (2)	No (0)
15. Because of your tinnitus, is it difficult for you to read?	Yes (4)	Sometimes (2)	No (0)
16. Does your tinnitus make you upset?	Yes (4)	Sometimes (2)	No (0)
17. Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?	Yes (4)	Sometimes (2)	No (0)
18. Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes (4)	Sometimes (2)	No (0)
19. Do you feel that you have no control over your tinnitus?	Yes (4)	Sometimes (2)	No (0)
20. Because of your tinnitus, do you often feel tired?	Yes (4)	Sometimes (2)	No (0)
21. Because of your tinnitus, do you feel depressed?	Yes (4)	Sometimes (2)	No (0)
22. Does your tinnitus make you feel anxious?	Yes (4)	Sometimes (2)	No (0)
23. Do you feel that you can no longer cope with your tinnitus?	Yes (4)	Sometimes (2)	No (0)
24. Does your tinnitus get worse when you are under stress?	Yes (4)	Sometimes (2)	No (0)
25. Does your tinnitus make you feel insecure?	Yes (4)	Sometimes (2)	No (0)

The sum of all responses is your THI Score >>> 0

0-16: Slight or no handicap (Grade 1)
18-36: Mild handicap (Grade 2)
38-56: Moderate handicap (Grade 3)
58-76: Severe handicap (Grade 4)
78-100: Catastrophic handicap (Grade 5)

Newman CW, Jacobson GP, Spitzer JB. (1996) "Development of the Tinnitus Handicap Inventory." Archives of Otolaryngology - Head and Neck Surgery. 122(2):143-8.
McCombe, A., Baguely, D., Coles, R., McKenna, L., McKinney, C. & Windle-Taylor, P. (2001). "Guidelines for the Grading of Tinnitus Severity: the Results of a

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MODIFIED Khalfa Hyperacusis Questionnaire (Khalfa et al, 2002)

Patient Name____ **Date**____________________

1.	Do you have trouble concentrating in a noisy or loud environment?	Yes	Sometimes	No
2.	Do you have trouble reading in a noisy or loud environment?	Yes	Sometimes	No
3.	Do you ever use earplugs or earmuffs to reduce your noise perception? (Do not consider the use of hearing protection during abnormally high exposure situations.)	Yes	Sometimes	No
4.	Do you find it harder to ignore sounds around you in everyday situations?	Yes	Sometimes	No
5.	Do you find it difficult to listen to speaker announcements (such as airport, airplanes, trains, etc.)?	Yes	Sometimes	No
6.	Are you particularly sensitive to or bothered by street noise?	Yes	Sometimes	No
7.	Do you "automatically" cover your ears in the presence of somewhat louder sounds?	Yes	Sometimes	No

F Subscale Total __________

8.	When someone suggests doing something (going out, to the cinema, to a concert, etc.), do you immediately think about the noise you are going to have to put up with?	Yes	Sometimes	No
9.	Do you ever turn down an invitation or not go out because of the noise you would have to face?	Yes	Sometimes	No
10.	Do you find the noise unpleasant in certain social situations (e.g., nightclubs, pubs or bars, concerts, firework displays, cocktail receptions)?	Yes	Sometimes	No
11.	Has anyone you know ever told you that you tolerate noise or certain kinds of sounds badly?	Yes	Sometimes	No
12.	Are you particularly bothered by sounds others are not?	Yes	Sometimes	No
13.	Are you afraid of sounds that others are not?	Yes	Sometimes	No

S Subscale Total __________

14.	Do noise and certain sounds cause you stress and irritation?	Yes	Sometimes	No
15.	Are you less able to concentrate in noise toward the end of the day?	Yes	Sometimes	No
16.	Do stress and tiredness reduce your ability to concentrate in noise?	Yes	Sometimes	No
17.	Do you find sounds annoy you and not others?	Yes	Sometimes	No
18.	Are you emotionally drained by having to put up with all daily sounds?	Yes	Sometimes	No
19.	Do you find daily sounds having an emotional impact on you?	Yes	Sometimes	No
20.	Are you irritated by sounds others are not?	Yes	Sometimes	No

E Subscale Total __________

Subscale Total __________