



Thank You for Taking the Time to Fill Out This Patient Form Prior to Your Visit.
Please follow the below instructions.

- 1 Download the PDF Form**
Please Note: Do Not Fill Out the Form Prior to Downloading. The Data Will Not Be Saved.
- 2 Fill Out the Form**
- 3 Save PDF as Your Name**
- 4 Email Completed Form to frontdesk@betterliving.email.**

Julie Bier, Au.D. • Corey Gibeault, Au.D.
Doctors of Audiology

54 West Twin Oaks Terrace, Suite 10 • South Burlington, VT 05403 • P: 802-651-9374 • F: 802-651-9376
135-A Creek Rd • Middlebury, VT 05753 • P: 802-989-7210 • F: 802-989-7348

betterlivingaudiology.com

Welcome to Better Living Audiology

Better Living Audiology is Northern Vermont's premier hearing and balance healthcare provider. Our Audiologists are doctors dedicated to providing the highest level of medically-oriented diagnostic and treatment services for individuals with hearing loss, tinnitus, and balance disorders. We provide state-of-the-art technology and truly professional care, according to your priorities.

What to Expect at your Appointment?

Your visit will include a variety of simple but technically advanced tests using computers and highly specialized equipment not available in most medical centers. There will be no pins or needle sticks. Your appointment will last 60-90 minutes.

Prior to each test, an explanation will be given so that you will have a better understanding of what is being tested and why. We make every attempt to make your visit comfortable as well as educational.

We will be sure to discuss the results whenever possible and send all results to your referring physician.

DOs and DON'Ts

So we can obtain accurate results, we ask that you please review the following instructions carefully:

1. Do bring your photo ID, Insurance Card, and a List of Medications.
2. Do not wear any makeup, including mascara, eye liner, or face lotions. These products may interfere with the recordings.
3. Do not drink caffeinated or alcoholic beverages for 48 hours before the test.
4. Do not use recreational drugs such as marijuana for 48 hours before the test.
5. Certain medications can influence the body's response to the test, thus giving a false or misleading result. If possible, please refrain from taking the following medications for 48 hours prior to your appointment. Anti-vertigo medicines: Anti-vert, Ru-vert, or Meclizine; Anti-nausea medicines: Atarax, Dramamine, Compazine, Antiver, Bucladin, Phenergan, Thorazine, Scopolamine.
6. Vital medications SHOULD NOT be stopped. Continue to take medications for heart, blood pressure, thyroid, anticoagulants, birth control, antidepressants, and diabetes. If you are unsure about discontinuing a particular medication, please call your physician to determine if it is medically safe for you to be without them for 48 hours.
7. Eat lightly the day of your appointment. If your appointment is in the morning, you may have a light breakfast such as toast and juice. If your appointment is in the afternoon, eat a light breakfast and have a light snack for lunch.
8. Testing may cause a sensation of motion that may linger. If possible, we encourage you to have someone accompany you to and from the appointment. However, if this is not possible, try to plan your day to include an extra 15-30 minutes after your test before leaving the office.



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Patient Information

(incomplete forms will delay your appointment)

Title: _____ First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Date of Birth: ___/___/_____ Gender: _____ Last 4 of Social Security #: _____

Home Phone #: _____ Cell #: _____ E-Mail: _____

Primary Contact: _____ Phone#: _____ Relationship: _____

Emergency Contact: _____ Phone#: _____ Relationship: _____

Primary Doctor: _____ Phone #: _____

Referring Doctor: _____ Phone #: _____

How did you hear about us? _____

The patient/legal guardian authorizes Better Living Audiology staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Consent to Release Medical Information

I authorize Better Living Audiology to release any information acquired in connection with my diagnostic/treatment services including, but not limited to, diagnosis & clinical records, to myself, my insurance(s), physician(s), and

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Better Living Audiology.

Primary Insurance Name _____ ID # _____ Group # _____

Primary Insurance Card Holder Name _____ Primary Card Holder Date of Birth ___ / ___ / ___

Secondary Insurance Name _____ ID # _____ Group # _____



Guarantee of Payment: I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

Cancellation/No Show Policy

I understand that my appointment is a reservation of time with a skilled health professional. Insufficient notice of missing an appointment detracts from my ability to get fully well and affects other patients as well. Appointments without sufficient notice (less than 24 hours) will be charged a \$25 fee. My insurance does not cover these fees and it will be my responsibility to pay. If I repeatedly neglect my appointments, the office may dismiss me as a patient.

I hereby certify that I understand these rights as set forth

I acknowledge that I have been informed of Better Living Audiology's Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information. A current copy of Better Living Audiology's Privacy Practices is available to you upon request.

Client/Responsible Party Signature: _____ Date: _____

Legal Representation (If applicable): Name: _____ Signature: _____



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Medical History

PATIENT NAME: _____

DATE: _____

Do you have, or have you had, any of the following?

Neurologic

- Migraine
- Stroke/TIA
If so, when? _____
- Parkinson's Disease
- Seizures/ Epilepsy
- Concussion/Head Injury
If so, when? _____
- Multiple Sclerosis
- Alzheimer's
- Other Neurologic _____

Cardiovascular

- Heart Attack
If so, when? _____
- Pacemaker
- Peripheral Arterial Disease
- High Blood Pressure
- Low Blood Pressure
- Other Cardiovascular _____

Respiratory

- Breathing Difficulties
- Emphysema/COPD
- Asthma
- Other Respiratory _____

Other Health Issues

Orthopedic

- Artificial Joints
If yes, which? _____
- Arthritis
- Back Problems
- Back Surgery
If so, when? _____
- Neck Problems
- Osteoporosis/Osteopenia
- Other Orthopedic _____

Vision

- Cataracts
If removed, when? _____
- Glaucoma
- Macular Degeneration
- Other Vision _____

Other

- Cancer
Type: _____
- Diabetes
- Neuropathy
- Depression
- Anxiety
- Thyroid
- Gastrointestinal Problems
- Rheumatoid Arthritis
- Tobacco Use
If yes, how much? _____
- Alcohol Use
If yes, how much? _____

Medical History

PATIENT NAME: _____

DATE: _____

Please list all of your current medications and supplements

Prescription	Dosage	Frequency	Route	Reason

Over the Counter	Dosage	Frequency	Route	Reason

Supplements & Vitamins	Dosage	Frequency	Route	Reason

Dizziness Handicap Inventory (DHI)

Initial Visit / Follow-up / Discharge

PATIENT NAME: _____ DATE: _____

Please mark an "x" in the appropriate box regarding your dizziness/imbalance symptoms

	YES	SOMETIMES	NO
P1 Does looking up increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E2 Because of your problem, do you feel frustrated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F3 Because of your problem, do you restrict your travel for business or recreation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P4 Does walking down the aisle of a supermarket increase your problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F5 Because of your problem, do you have difficulty getting into or out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F6 Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F7 Because of your problem, do you have difficulty reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P8 Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E9 Because of your problem, are you afraid to leave your home without having someone accompany you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E10 Because of your problem have you been embarrassed in front of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P11 Do quick movements of your head increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F12 Because of your problem, do you avoid heights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P13 Does turning over in bed increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F14 Because of your problem, is it difficult for you to do strenuous homework or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E15 Because of your problem, are you afraid people may think you are intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16 Because of your problem, is it difficult for you to go for a walk by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P17 Does walking down a sidewalk increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E18 Because of your problem, is it difficult for you to concentrate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19 Because of your problem, is it difficult for you to walk around your house in the dark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E20 Because of your problem, are you afraid to stay home alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E21 Because of your problem, do you feel handicapped?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E22 Has the problem placed stress on your relationships with members of your family or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E23 Because of your problem, are you depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F24 Does your problem interfere with your job or household responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P25 Does bending over increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Used with permission from GP Jacobson. Jacobson GP, Newman CW: The development of the Dizziness Handicap Inventory. Arch Otolaryngol. Head Neck Surg 1990;116: 424-427

For Office Use Only
Score P: _____ E: _____ F: _____

16-34 Points (mild)
36-52 Points (moderate)
54+ Points (severe)

Patient Questionnaire

PATIENT NAME: _____

DATE: _____

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur? _____

How long did it last? _____

1. Do you experience any of the following sensations? Please read the entire list first. Then put an 'x' in either the first box for YES or the second box for NO to describe your feelings most accurately.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Do you experience motion, air or sea sickness?
<input type="checkbox"/>	<input type="checkbox"/>	Did you have motion sickness as a child?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a family history of motion sickness? <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Child
<input type="checkbox"/>	<input type="checkbox"/>	Do you have migraine headaches?
<input type="checkbox"/>	<input type="checkbox"/>	Were you exposed to any solvents, chemicals, etc.?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever fallen? How many times? _____
		Where? _____ <input type="checkbox"/> Inside the home <input type="checkbox"/> Outside the home
<input type="checkbox"/>	<input type="checkbox"/>	Are you afraid of falling?

2. If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please go to the next section (3).

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	My dizziness is constant? If you answered yes, please go to section 3.
<input type="checkbox"/>	<input type="checkbox"/>	If in attacks, how often? _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you completely free of dizziness between attacks?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any warning that the attack is about to start?
<input type="checkbox"/>	<input type="checkbox"/>	Is the dizziness provoked by head/body movement? If so, which direction? _____
<input type="checkbox"/>	<input type="checkbox"/>	Is the dizziness worse at any particular time of the day?
		If so, when? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you know of anything that will stop your dizziness or make it better?
		What? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you know of anything that will make your dizziness worse?
		What? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you know of anything that will precipitate an attack?
		What? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you know any possible cause of your dizziness?
		What? _____

Patient Questionnaire

PATIENT NAME: _____ DATE: _____

3. Do you experience any of the following sensations? Please read the entire list first then please check the box for either YES or NO to describe your feelings most accurately.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Light headedness?
<input type="checkbox"/>	<input type="checkbox"/>	Swimming sensation in the head?
<input type="checkbox"/>	<input type="checkbox"/>	Blacking out or loss of consciousness?
<input type="checkbox"/>	<input type="checkbox"/>	Objects spinning or turning around you?
<input type="checkbox"/>	<input type="checkbox"/>	Sensation that you are turning or spinning inside, with outside objects remaining stationary?
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to fall to the right or left?
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to fall forward or backward
<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance when walking, veering to the right?
<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance when walking, veering to the left?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have trouble walking in the dark?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have problems turning to one side or the other?
<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting?
<input type="checkbox"/>	<input type="checkbox"/>	Pressure in the head?

4. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if In Episodes.

YES	NO			
<input type="checkbox"/>	<input type="checkbox"/>	Double vision?	<input type="checkbox"/> Constant	<input type="checkbox"/> In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision or blindness?	<input type="checkbox"/> Constant	<input type="checkbox"/> In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Spots before your eyes?	<input type="checkbox"/> Constant	<input type="checkbox"/> In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Numbness of face, arms or legs?	<input type="checkbox"/> Constant	<input type="checkbox"/> In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Weakness in arms or legs?	<input type="checkbox"/> Constant	<input type="checkbox"/> In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Confusion or loss of consciousness?	<input type="checkbox"/> Constant	<input type="checkbox"/> In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in swallowing? Tingling around the mouth?	<input type="checkbox"/> Constant	<input type="checkbox"/> In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty speaking?	<input type="checkbox"/> Constant	<input type="checkbox"/> In Episodes

5. Do you have any of the following? Please check the box for either YES or NO and circle the ear involved.

YES	NO				
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in hearing?	<input type="checkbox"/> Both Ears	<input type="checkbox"/> Right Ear	<input type="checkbox"/> Left Ear
<input type="checkbox"/>	<input type="checkbox"/>	When did this start? _____	Is it getting worse? _____		
<input type="checkbox"/>	<input type="checkbox"/>	Does the hearing change with your symptoms? If so, how? _____			
<input type="checkbox"/>	<input type="checkbox"/>	Noise in your ears?	<input type="checkbox"/> Both Ears	<input type="checkbox"/> Right Ear	<input type="checkbox"/> Left Ear
<input type="checkbox"/>	<input type="checkbox"/>	Describe the noise? _____			
<input type="checkbox"/>	<input type="checkbox"/>	Does the noise change with your symptoms? If so, how? _____			
<input type="checkbox"/>	<input type="checkbox"/>	Does anything stop the noise or make it better? _____			
<input type="checkbox"/>	<input type="checkbox"/>	Fullness or stuffiness in your ears?	<input type="checkbox"/> Both Ears	<input type="checkbox"/> Right Ear	<input type="checkbox"/> Left Ear
<input type="checkbox"/>	<input type="checkbox"/>	Does this change when you are dizzy? _____			
<input type="checkbox"/>	<input type="checkbox"/>	Pain in your ears?	<input type="checkbox"/> Both Ears	<input type="checkbox"/> Right Ear	<input type="checkbox"/> Left Ear
<input type="checkbox"/>	<input type="checkbox"/>	Discharge from your ears?	<input type="checkbox"/> Both Ears	<input type="checkbox"/> Right Ear	<input type="checkbox"/> Left Ear

