

Medical History:

Please include any significant events, accidents, surgeries, ages when these occurred, or inherited conditions, congenital disorders, or family history related to auditory function.

Current Medications:

Age of Onset of Symptoms, to best recollection: Please note first memory-description of triggers.

Any treatments tried for Selective Sound Sensitivity in the past?

Effectiveness of above:

Worse Scenarios-Triggers: Please list the main sounds that cause problems:

Is there someone that is associated with the worst-case triggers

Worse Scenario Incidents:

Please list the reactions experienced or expressed (self harm, flight, verbal or body expressions of anger, frustration, rage, sorrow, confusion, etc.)

Length of Time Required for Recovery from Reactions:

Activities or Actions that can positively affect the Reactions, either the intensity of the reactions or the duration of the reaction:

Best Case Scenario: What activities are the most comfortable for the patient, when are they happiest?

Are earplugs used, how often? Ear muffs? Noise cancellation devices?

Family/friends Living with Patient:

What daily living activities are affected by the Selective Sound Sensitivity? What is the impact on the other members of the household?

What medical providers have been consulted? .

What advice was rec'd prior to this time?

Other related conditions/behaviors/sensitivities? Please note any other problems related to sensory impacts?

Any other important information?

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 _____

MISOPHONIA ASSESSMENT QUESTIONNAIRE: MAQ

Twenty One Questions

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

Misophonia Family/SigOther Assessment QUESTIONNAIRE
 The F-MAQ, 2014, Dr. Marsha Johnson, AuD, can be used with permission

NAME: _____ DATE: _____

Relationship: ___ Parent ___ Sibling ___ Spouse/SO ___ other

RATING SCALE : 0 = not at all, 1 = a little of the time, 2 = a good deal of the time, 3 = almost all the time N/A Not applicable/unable to answer

Answer each question as you are able.	0	1	2	3	N/A
1. Sound sensitivity issues significantly impact our family happiness.					
2. Sound sensitivity issues have significant changed our regular family lifestyle.					
3. Sound sensitivity issues negatively impact our family's regular routines or habits.					
4. Sound sensitivity issues and negative impact are greater at home.					
5. Sound sensitivity issues and negative impact are greater outside the home.					
6. Sound sensitivity issues have impacted my marital life (routine habits and behaviors).					
7. Sound sensitivity issues have created significant stress between parents or adult members of the family.					
8. Sound sensitivity issues have created significant stress between siblings.					
9. Sound sensitivity issues have resulted in verbal arguments.					
10. Sound sensitivity issues have resulted in physical violence or attempted violence or threats of violence.					
11. Sound sensitivity issues disrupt our normal routine at home.					
12. Sound sensitivity issues disrupt out of the home activities, plans, travel, recreation, social, or other activity.					
13. I am one of the main triggers for the affected person.					
14. I am being asked to vary my own normal behaviors or actions to avoid triggering someone else.					
15. I feel that the sound sensitive person could control their negative reactions if they wanted.					
16. When I try to reach out and try to help, I feel that I am shut out and my approach is rejected.					
17. We have been unable to locate appropriate and effective treatment for our family member.					
18. I am worried or anxious about the future of our family life and the impact this condition will have.					
TOTAL SCORE					

