

KIRSCH THERAPY

EVALUATION QUESTIONNAIRE

1. What are you being seen for today? _____

2. Please describe your problem. _____

3. How long have you had this problem? _____
4. Have you received treatment for this before? _____ Where, when and for how long? _____

5. Have you been diagnosed with any illnesses or diseases? _____ Please list:

6. Do you have any allergies? _____ To what: _____
7. Are you currently taking any medications? _____ What/For what? _____

8. Have you been hospitalized or had any major accidents or surgeries? _____
Please explain _____

9. Have you had your hearing checked? _____ What were the results? _____

10. Do you have any other questions or concerns you would like addressed? _____

