## APPENDIX 1

### Sound Plan Worksheet

1. Write down one bothersome tinnitus situation

2. Check one or more of the three ways to use sound to manage the situation

   - [ ] Soothing sound
   - [ ] Background sound
   - [ ] Interesting sound

3. Write down the sounds that you will try

4. Write down the devices you will use

5. Use your sound plan over the next week. How helpful was each sound after using it for 1 week?

   - Not at all
   - A little
   - Moderately
   - Very much
   - Extremely

   ![Soothing sound](image1.png)

   ![Background sound](image2.png)

   ![Interesting sound](image3.png)

6. Comments

   When you find something that works well (or not so well) please comment. You do not need to wait 1 week to write your comments.

   ![Soothing sound](image1.png)

   ![Background sound](image2.png)

   ![Interesting sound](image3.png)
### APPENDIX 2 Changing Thoughts and Feelings Worksheet

#### Changing Thoughts and Feelings Worksheet

1. From the Tinnitus Problem Checklist, write down one bothersome tinnitus situation

<table>
<thead>
<tr>
<th>2. Check one or more of the three exercises you will practice</th>
<th>3. Write down how you feel before you try the exercise</th>
<th>4. Write down how you feel after the exercise</th>
<th>5. Use your plan plan over the next week. How helpful was each exercise?</th>
<th>6. Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep breathing</td>
<td></td>
<td></td>
<td>Not at all</td>
<td>A little</td>
</tr>
<tr>
<td>Inhale</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breathe</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exhale</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imagery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See, hear, touch</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imagine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smell, taste</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changing thoughts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Think</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Trial 1
d
Trial 2
d
Trial 3
d
APPENDIX 3 – Tinnitus and Hearing Survey

A. Tinnitus

<table>
<thead>
<tr>
<th>Over the last week, tinnitus kept me from sleeping.</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the last week, tinnitus kept me from concentrating on reading.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Over the last week, tinnitus kept me from relaxing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Over the last week, I couldn’t get my mind off of my tinnitus.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

B. Hearing

<table>
<thead>
<tr>
<th>Over the last week, I couldn’t understand what others were saying in noisy or crowded places.</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the last week, I couldn’t understand what people were saying on TV or in movies.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Over the last week, I couldn’t understand people with soft voices.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Over the last week, I couldn’t understand what was being said in group conversations.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

C. Sound Tolerance

<table>
<thead>
<tr>
<th>Over the last week, everyday sounds were too loud for me.*</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

If you responded 1, 2, 3 or 4 to the statement above:

<table>
<thead>
<tr>
<th>Being in a meeting with 5 to 10 people would be too loud for me.*</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

*If sounds are too loud for you when wearing hearing aids, please tell your audiologist
APPENDIX 4

TRAUMATIC BRAIN INJURY SCREEN
(Modified from VA Traumatic Brain Injury Screen)

Have you ever been diagnosed as having Traumatic Brain Injury (TBI)?
- Yes
- No
  - If “Yes” it is not necessary to ask any of the questions below. Ensure that patient has satisfactory access to care related to TBI.
  - If “No” then continue with the four sections below.

1. Have you ever experienced any of the following events? (check all that apply)
- Blast or Explosion (IED, RPG, land mine, grenade, etc.)
- Vehicular accident/crash (any vehicle, including aircraft)
- Fragment wound or bullet wound above the shoulders
- Fall
- Blow to the head (head hit by falling/flying object, head hit by another person, head hit against something, etc.)
- Other injury to head

  - If none of the items above were endorsed then the patient has screened negative for TBI, and it is not necessary to ask any of the questions below.
  - If one or more of the items in section 1 were endorsed, then continue with the questions below.

2. Did you have any of these symptoms IMMEDIATELY afterwards? (check all that apply)
- Losing consciousness or “knocked out”
- Being dazed, confused or “seeing stars”
- Not remembering the event
- Concussion
- Head injury

  - If none of the items above were endorsed then the patient has screened negative for TBI, and it is not necessary to ask any of the questions below.
  - If one or more of the items in section 2 were endorsed, then continue with the questions below.

3. Did any of the following problems begin or get worse afterwards? (check all that apply)
- Memory problems or lapses
- Balance problems or dizziness
- Sensitivity to bright light
- Irritability
☐ Headaches
☐ Sleep problems

- If *none* of the items above were endorsed then the patient has screened negative for TBI, and it is not necessary to ask any of the questions below.
- If *one or more* of the items in section 3 were endorsed, then continue with the questions below.

4. **In the past week have you had any of the symptoms from question 3? (check all that apply)**
   - Memory problems or lapses
   - Balance problems or dizziness
   - Sensitivity to bright light
   - Irritability
   - Headaches
   - Sleep problems

- If *none* of the items above were endorsed, then the patient has screened negative for TBI.
- If *one or more* of the items in section 4 were endorsed, then the **patient has screened positive for TBI and should be referred for further evaluation.**