COMMUNICATION ASSESSMENT

Name:____ Date: _______________________

The purpose of this form is to identify the problems a hearing loss may be causing you. If you have a hearing aid, please fill out the form according to how you communicate when your hearing aids are NOT in use. One of the five descriptions below.

1) Almost Never (or never)
2) Occasionally (about 1/4 of the time)
3) About 1/2 of the time
4) Frequently (about 3/4 of the time)
5) Practically always or always

Please select a number from 1 to 5 next to each statement

Statement					
Avoid social situations because you have difficulty hearing	1	2	3	4	5
Ask people to repeat themselves	1	2	3	4	5
Hear words but do not understand them	1	2	3	4	5
Difficulty hearing people in noisy places	1	2	3	4	5
Been told that you speak loudly	1	2	3	4	5
Been told to turn down the television by others	1	2	3	4	5
Find loud sounds bothersome	1	2	3	4	5
Difficulty hearing a speaker at meetings or church	1	2	3	4	5
Prefer one on one conversations	1	2	3	4	5
Have difficulty hearing someone from across the room	1	2	3	4	5
Find it difficult to hear children's voices	1	2	3	4	5

Please rate the following from 1 to 4 in order of importance to you (1-Most Important, 4-Least Important):

Item				
Overall Sound Quality	1	2	3	4
Reliability	1	2	3	4
Price	1	2	3	4
Appearance/Style	1	2	3	4

Name 3 situations where you would like to hear better____
____

Any questions or comments for the doctor? ____
____
____

___________________________________ ____________________
Patient Signature Date