



COMMUNICATION ASSESSMENT

Name: _____ Date of Birth: _____

1. Do you feel that your hearing affects your personal or professional life?

Yes No Sometimes

2. Does your difficulty hearing upset you?

Yes No Sometimes

3. Do other people suggest that you have a hearing loss?

Yes No

4. Have hearing aid(s) ever been recommended for you?

Yes No

5. Would you consider the use of hearing aids?

Yes No Maybe

6. Do you currently wear hearing aids?

Yes No If yes, for how long: _____

7. What are the three most important situations you would like to improve on (i.e. business meetings, speaking with your spouse and communicating on the phone)?

1. _____

2. _____

3. _____

Please select the response that best describes your lifestyle and hearing difficulty:

8. You often spend quite a bit of time in one to one situations.

Never Rarely Sometimes Often Always

9. You need to be able to hear in a small group settings or social gatherings (i.e. family dinners).

Never Rarely Sometimes Often Always



10. You are actively working or need to communicate in business meetings and other challenging listening environments throughout the day.

Never Rarely Sometimes Often Always

11. You often attend large parties, go to busy restaurants or events where there is a presence of background noise.

Never Rarely Sometimes Often Always

12. You are often in large auditoriums or involved in religious gatherings and lectures within the community.

Never Rarely Sometimes Often Always

13. You often spend quite a bit of time involved in home activities like watching television and/or cooking.

Never Rarely Sometimes Often Always

14. You often spend quite a bit of time on the landline telephone.

Never Rarely Sometimes Often Always

15. You often need to communicate on your smartphone daily.

Never Rarely Sometimes Often Always