

Your Name _____ Today's Date _____

1. What brought you to our office today? _____
2. Please check the box below that best applies to your current hearing abilities in various environments.
Select one: with hearing aids without hearing aids

Listening Environments	How well do you currently hear in this environment?			How frequently are you in this listening environment?		
	WELL	FAIR	POOR	OFTEN	SOMETIMES	RARELY
One-to-One Conversations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Small Groups (4-6 people)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Large Social Gatherings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the Workplace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching Television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During Religious Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meetings / Lectures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the Car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outdoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On the Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. What is your experience with hearing aids? (check all that apply)
 - I have never used or visited a Hearing Health Care Professional to inquire about a hearing aid(s).
 - I have been to another Hearing Health Care Professional to gather information regarding my hearing difficulties, but have not tried or purchased a hearing aid(s).
 - I have tried a hearing aid(s) but returned the instrument(s).
 - I have a hearing aid(s) but only wear it occasionally or not at all.
 - I am a hearing aid wearer and use it regularly on the right ear, left ear, both ears.
4. Please rank the following in terms of the importance in a hearing aid. (1 through 4, with 1 being the most important)

_____ Overall Sound Quality _____ Reliability _____ Style/Appearance _____ Cost
5. On a scale of 1-10, how motivated are you regarding doing something about your hearing loss? (Please circle one)

1	2	3	4	5	6	7	8	9	10
Not Motivated	Somewhat Motivated	Motivated	Very Motivated	Extremely Motivated					