Name:_____ Date:_____

HEARING ABILITIES QUESTIONNAIRE

1. Please check the box which best corresponds to your ability to hear in the situations listed. Also be sure to check how often you are in that situation.

Listening Situation	How well do you hear in this situation?			How often are you in this situation?		
	Poor	Fair	Good	Rarely	Sometimes	Often
Quiet Room with 1-2 people						
Television/Radio/Music						
Restaurants						
Church						
Meetings/Lectures						
Work Place						
Telephone Conversation						
Car						
Meals (at home)						
Groups (4-6 or more people)						
Large Social Gathering						
Radio						

2. What is your hearing aid experience?

   _____ I have hearing device(s) which I use regularly on my ___left ___ right ear(s).

   _____ I have a hearing device, but I don't use it, or use it.

   _____ I tried a hearing aid but returned it for credit.

   _____ I have inquired about hearing devices at another office(s) abut did not purchase at that time.

   _____ I have never used a hearing device.

3. Please rank the following (using 1, 2, 3, and 4 in terms of what is most important to you when purchasing a hearing device. 1= Most important and 4 = Least Important. Please use each number only once.

   _____ Sound Quality and Clarity _____ Durability/Reliability ____ Cost _____ Appearance

4. What motivated you to come in today?

   _____

5. On a scale of one to ten (1-10) where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? Please circle one number.

1	2	3	4	5	6	7	8	9	10
not motivated									very motivated