Hearing Needs Assessment

1. What is your hearing aid experience?

- ❑ I have a hearing device and use it regularly on the _____ right ear, _____left ear.
- ❑ I have a hearing device, but don't use it, or use it only occasionally.
- ❑ I tried a hearing device, but returned it for credit.
- ❑ I have inquired about hearing devices at another office(s), but did not purchase.
- ❑ I have never used a hearing device.

2. Using a 1, 2, 3, and 4, rank the following in order of importance to you regarding a hearing device:
1,being your first choice , then 2, your 2nd choice, 3 , your 3rd choice, 4, your 4th choice.
_____ Sound Quality & Clarity ____ Durability/Reliability ____ Cost ____ Appearance

3. What motivated you to come in today?

_____

4. On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (1 being least and 10 Most Motivated)

1 2 3 4 5 6 7 8 9 10 {Please circle one}

5. Please check the box which corresponds to your ability to hear in the situations listed and 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 (1 to 2 People)	❑	❑	❑	❑	❑	❑
Restaurants	❑	❑	❑	❑	❑	❑
Car	❑	❑	❑	❑	❑	❑
Television	❑	❑	❑	❑	❑	❑
Church	❑	❑	❑	❑	❑	❑
Meetings/Lectures	❑	❑	❑	❑	❑	❑
Work Place	❑	❑	❑	❑	❑	❑
Telephone	❑	❑	❑	❑	❑	❑
Large Social Gatherings	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑