Companion Questionnaire

HRC HEARING REHAB CENTER

Name _____ **Patient Name** _____

Relation to Patient _____ **Date** _____

Family, friends, and loved ones are often the first to notice changes in our patient's hearing. Please take a moment to answer the following questions to help us better understand the difficulties your companion may be having.

Does your companion:	**Yes**	**No**
have difficulty with telephone conversation?	**Yes**	**No**
struggle to hear in noisy situations, like restaurants?	**Yes**	**No**
increase the volume on television or radio to a level that is uncomfortable for others?	**Yes**	**No**
say that people mumble?	**Yes**	**No**
often ask people to repeat themselves?	**Yes**	**No**
feel like they hear words but don't understand them?	**Yes**	**No**
have difficulty hearing women's and children's voices?	**Yes**	**No**
withdraw from or want to skip social situations where they know they may have difficulty hearing?	**Yes**	**No**

Please provide the three most important listening situations where you would like your companion to hear better

1. _____

2. _____

3. _____

Companion Questionnaire

If your companion does not currently use technology, please skip this section.

With their current technology, I think my companion hears well:

	Always	Sometimes	Never
1. while in background noise?	A	S	N
2. in the car?	A	S	N
3. on the phone?	A	S	N
4. in a conference room?	A	S	N
5. in a restaurant?	A	S	N
6. while listening to music?	A	S	N
7. while watching TV ?	A	S	N
8. in group conversations?	A	S	N
9. in conversations with their spouse?	A	S	N

Additional comments _____