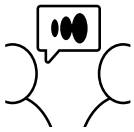
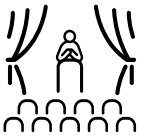
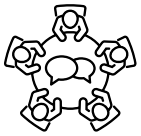
Companion Communication Questionnaire

Name _____ DOB ____/____/____

Companion Name _____ Relationship _____

Please check the box for each area where you notice that your significant other has hearing difficulties.
Be sure to consider their hobbies and your favorite memories.

☐  One on One Conversations	☐  Small Group Conversation	☐  TV/Movies	☐  Music/Radio	☐  Telephone
☐  In the Car	☐  Outdoor	☐  Theater/Worship	☐  Family Gatherings/ Meetings	☐  Restaurants/Parties

Of these, what situations are important to you that they hear better:

1. _____

2. _____

3. _____

Do you notice them withdrawing from conversations? ☐ Yes ☐ No

Do you notice that they seem frustrated trying to listen? ☐ Yes ☐ No

Do you notice them avoiding places because they cannot hear well? ☐ Yes ☐ No

Do they ask others to repeat? ☐ Yes ☐ No

If new hearing aids are recommended, are you ready for them to move forward today?

☐ Yes ☐ No ☐ Maybe

_____ _____

Signature Date