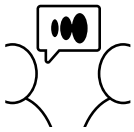
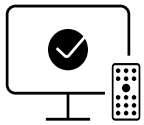
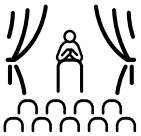
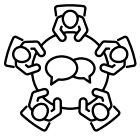
Companion Communication Questionnaire

Name _____ DOB ____/____/____

Companion Name _____ Relationship _____

Please check the box for each area where you notice your companion has difficulty hearing. Think about everyday moments, their hobbies, and even your favorite shared memories when making your selections.

☐  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