Living WELL with Hearing Loss
Adult Audiologic Rehabilitation Program
Contact Information Sheet (PHL)

NAME:_____ DATE:_____

DATE OF BIRTH: _____AGE: _____

STREET ADDRESS: _____

CITY/STATE: _____

HOME PHONE: _____CELL: _____

EMAIL: _____

OCCUPATION (current or previous): _____

COMMUNICATION PARTNER (relation to you?)_____

1. Does your communication partner have a hearing loss? _____YES _____NO
2. How did you hear about our class?_____
3. Have you noticed difficulty hearing? _____YES _____NO
4. When did you first start noticing the problem? _____
5. What are your most challenging hearing/communication situations?

   _____

   _____

6. Have you ever worn hearing aids? _____YES _____NO
7. Do you wear them now? _____YES _____NO
8. Do your hearing aids have a telecoil (T-program)?

   ☐YES ☐YES,BUT I DO NOT USE IT ☐NO ☐I DON'T KNOW

9. Have you been satisfied with your hearing aids? _____
10. Who is your audiologist? _____
11. What would you like to learn from this class?

    _____

    _____

12. Do you want to be notified by email of future lectures or events on hearing?

    _____YES _____NO

13. Do you want to be contacted for research projects? _____YES _____NO