Living WELL with Hearing Loss
Adult Audiologic Rehabilitation Program
Information Sheet
Communication Partner

NAME:_____DATE:_____

DATE OF BIRTH: _____ AGE: _____

STREET ADDRESS: _____

CITY/STATE: _____

HOME PHONE: _____ CELL: _____

EMAIL: _____

OCCUPATION (current or previous): _____

1. What are your most challenging hearing/communication situations?

   _____

   _____

2. If your partner wears hearing aids, how effective do you think they are?

   _____

3. Based on the level of difficulty that you and your partner are experiencing due to hearing loss, how motivated do you think **YOUR PARTNER** is to change as a result of this class?

   Please check one:

   _____Very Motivated _____Motivated _____Not Very Motivated _____ Unmotivated

4. What would you like to learn from this class?

   _____

   _____

   _____

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

   _____YES _____NO

6. Do you want to be contacted to participate in research projects?

   _____YES _____NO