

**ASPEN HEARING CENTER
HEARING INSTRUMENT HISTORY AND NEEDS ASSESSMENT**

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

1. What motivated you to come in today? _____

2. Hearing aid history:

- ___ I have a hearing device and use it regularly on the right ear ___ left ear ___.
- ___ I have a hearing device, but don't use it, or use it only occasionally.
- ___ I tried a hearing device, but returned it for credit.
- ___ I have inquired about hearing devices at another office, but did not purchase.
- ___ I have never used a hearing device.

3. If we find out hearing aids can help you, how would you rank these four items from most important to least important in your purchasing decision? 1=most important, 4=least important

___ Sound Quality ___ Durability/Reliability ___ Cost ___ Appearance

4. On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially,) regarding doing something about your hearing loss? (Please circle one).

1 2 3 4 5 6 7 8 9 10

Create a list of places or situations that you have difficulty hearing or communicating. Be as specific as you can, this will help in finding the right solution for your individual needs. Try to involve your spouse if at all possible.

Example: I have difficulty understanding my guests when out to dinner at a crowded Applebee's Restaurant. Try to rank them from the most frustrating situation to the least in order one through four.

- 1. _____
- 2. _____
- 3. _____
- 4. _____

