3080 Yonge St., Suite 4074
Toronto ON M4N 3N1
416-488-4422

1386 Bayview Ave., Unit 3
Toronto ON M4G 3A1
416-482-4333

Global Hearing Aid Clinic

COMPANION QUESTIONNAIRE

Companion Name: _____ **Patient Name:** _____

Relationship to Patient: _____ **Date:** _____

In our professional experience, we have found that many of our patients describe hearing loss as the perception of Sound Voids® that affect not only their normal daily routines but the lives of those around them. We would like to ask you a few situational questions to better understand your companion's listening lifestyle and how we might improve their quality of life.

How often does a hearing problem…	**Always**	**Sometimes**	**Never**
Makes it difficult for your companion to converse on the phone?	☐	☐	☐
Cause you to complain that your companion turns up the television radio too loud?	☐	☐	☐
Cause your companion to have difficulty following conversation in a restaurant?	☐	☐	☐
Limit or hamper your companion's personal or social life?	☐	☐	☐
Cause your companion to have to have to ask others to repeat themselves?	☐	☐	☐
Cause your companion to have difficulty hearing when in presence of background noise?	☐	☐	☐
Cause your companion to have difficulty hearing women's or children's voices?	☐	☐	☐
Cause your companion to hear people but fail to understand what they are saying?	☐	☐	☐
Cause your companion to feel as though others mumble?	☐	☐	☐
Cause your companion to feel stressed or tired when listening for long periods of time?	☐	☐	☐

Please provide the top three listening situations where you would like your companion to hear better.

1 _____

2 _____

3 _____

Please select your companion's current and (if different) desired lifestyles.

Active Lifestyle (Frequent Background Noise)
O Current O Desired

Casual Lifestyle (Occasional Background Noise)
O Current O Desired

Quiet Lifestyle (Limited Background Noise)
O Current O Desired

Very Quiet Lifestyle (Rare Background Noise)
O Current O Desired

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If your companion does not currently use hearing aid(s), please skip this section.

My companion has difficulty hearing when using hearing aid(s)…

	Always	Sometimes	Never
While in background noise	☐	☐	☐
In the car	☐	☐	☐
On the phone	☐	☐	☐
In a conference room	☐	☐	☐
In a restaurant	☐	☐	☐
While listening to music	☐	☐	☐
While watching TV	☐	☐	☐
In group conversation	☐	☐	☐
In conversation with family	☐	☐	☐
In conversation with women and children	☐	☐	☐

Additonal Comments:

_____
_____
_____
_____
_____

Companion Signature: _____ *Date:* _____