Texas Workforce Commission
Vocational Rehabilitation Services

Hearing Evaluation Report Customer Questionnaire

Instructions

Please complete all of the information and questions on this form.

Customer Information

Customer Name:	Case ID:
Phone:	Date of birth:

Customer Questionnaire

To be completed by the counselor or customer before or during the diagnostic interview.

Reported disability:

Reason for referral:

Referral source:

Hearing Disability Information

When did you first notice your hearing loss or problem?

Did it happen slowly or suddenly?

Is there a family history of hearing loss? Yes No

If yes, in whom?

What caused your hearing loss?

Do you have pain in your ears? Yes No | Do you have drainage in your ears? Yes No

Is there noise in your head or ears? (select one) None Seldom Frequent

Is dizziness or balance a problem? (select one) None Seldom Frequent

When do you hear best?

When do you have the most difficulty hearing?

Can you understand what is said on the phone? Yes No

Can you understand what is said on the TV? Yes No

Can you understand what is said on the radio? Yes No

Do you have difficulty locating sound? Yes No
Have you ever worn a hearing aid? Yes No
Age when first used a hearing aid?
Do the hearing aids help? Yes No
If no, why not?
Is there anything wrong with your current aids?
Have you had speech training? Yes No
Have you had lip-reading training? Yes No
List the ways you communicate:
Please describe any visual, cognitive, and/or physical conditions you have that affects your ability to communicate:
Did you lose a job, fail to get a job, or change jobs because of your hearing problems?
If employed, what hearing problems do you have at work?
Other information about your hearing problems.