RECORDED SPEECH ASSESSMENTS

Spondee Word List - List A

1. GREYHOUND ☐	10. DUCKPOND ☐	19. BASEBALL ☐	28. OATMEAL ☐
2. SCHOOLBOY ☐	11. SIDEWALK ☐	20. STAIRWAY ☐	29. TOOTHBRUSH ☐
3. INKWELL ☐	12. HOTDOG ☐	21. COWBOY ☐	30. FAREWELL ☐
4. WHITEWASH ☐	13. PADLOCK ☐	22. ICEBERG ☐	31. GRANDSON ☐
5. PANCAKE ☐	14. MUSHROOM ☐	23. NORTHWEST ☐	32. DRAWBRIDGE ☐
6. MOUSETRAP ☐	15. HARDWARE ☐	24. RAILROAD ☐	33. DOORMAT ☐
7. EARDRUM ☐	16. WORKSHOP ☐	25. PLAYGROUND ☐	34. HOTHOUSE ☐
8. HEADLIGHT ☐	17. HORSESHOE ☐	26. AIRPLANE ☐	35. DAYBREAK ☐
9. BIRTHDAY ☐	18. ARMCHAIR ☐	27. WOODWORK ☐	36. SUNSET ☐

NU #6 half-lists, Forms A, B, C, D, arranged with the 10 most difficult words listed first.

Form A	Form B	Form C	Form D
1. KNOCK ☐	1. RAISE ☐	1. GIN ☐	1. PAD ☐
2. KITE ☐	2. PAGE ☐	2. PICK ☐	2. MATCH ☐
3. TAKE ☐	3. CHALK ☐	3. PIKE ☐	3. DEEP ☐
4. KEEN ☐	4. LAUD ☐	4. SHACK ☐	4. CHIEF ☐
5. PUFF ☐	5. DEATH ☐	5. DAB ☐	5. GAZE ☐
6. HASH ☐	6. THIRD ☐	6. TURN ☐	6. ROT ☐
7. TIP ☐	7. BEAN ☐	7. KEEP ☐	7. HAZE ☐
8. POOL ☐	8. SIZE ☐	8. TOOL ☐	8. CALM ☐
9. BURN ☐	9. MET ☐	9. BITE ☐	9. SOUTH ☐
10. SUB ☐	10. JAR ☐	10. JUICE ☐	10. NICE ☐
11. FAT ☐	11. HURL ☐	11. TON ☐	11. CHAIR ☐
12. YES ☐	12. WEEK ☐	12. FAIL ☐	12. SHAWL ☐
13. FALL ☐	13. CHOICE ☐	13. MERGE ☐	13. SAID ☐
14. WHICH ☐	14. GAP ☐	14. HUSH ☐	14. GOAL ☐
15. SELL ☐	15. MODE ☐	15. MILL ☐	15. SOAP ☐
16. KING ☐	16. BOAT ☐	16. BOUGHT ☐	16. WAG ☐
17. LOT ☐	17. TOUGH ☐	17. DEAD ☐	17. KEG ☐
18. RAID ☐	18. DIME ☐	18. FAR ☐	18. WITCH ☐
19. VINE ☐	19. WHIP ☐	19. THOUGHT ☐	19. LOAF ☐
20. JAIL ☐	20. SURE ☐	20. LEARN ☐	20. READ ☐
21. REACH ☐	21. DOOR ☐	21. LIVE ☐	21. HATE ☐
22. RAG ☐	22. SHOUT ☐	22. ROOM ☐	22. RAIN ☐
23. HOME ☐	23. MOON ☐	23. BOOK ☐	23. NUMB ☐
24. GOOSE ☐	24. NAG ☐	24. YOUNG ☐	24. VOICE ☐
25. LOVE ☐	25. LIMB ☐	25. WHITE ☐	25. LORE ☐

HEARING HEALTH REPORT

CLIENT HISTORY

PLEASE PRINT

Today's Date _____ - _____ - _____

Last Name _____ First Name _____ MI _____

Address _____ ❑ Male ❑ Female ❑ Married ❑ Single ❑ Widow(er)

City _____ State _____ Zip _____ County _____

Phone ( ) _____ - _____ E-mail Address _____

Date of Birth _____ - _____ - _____ Past/Present Occupation _____

Accompanying Party or Companion _____ Relationship _____

Primary Care Physician Name _____ City _____ Phone _____

Insurance Carrier _____ I.D. No./Policy No. _____

Permission to release a copy of test information to physician? ❑ Yes ❑ No Patient's Signature _____

MEDICAL AND HEARING HEALTH HISTORY

Do you have any allergies? ❑ Yes ❑ No If yes, please list _____

Are you currently taking any medications? ❑ Yes ❑ No If yes, please list _____

Are you taking any blood thinners? ❑ Yes ❑ No If yes, please list _____

Do you have ringing or other noises in your ears? ❑ Yes ❑ No If yes, which ear? _____

Have you previously had a hearing test? ❑ Yes ❑ No If yes, by whom and when? _____

Please check (√) if you have experienced any of the following ___Diabetes ___Arthritis/Rheumatoid Arthritis ___Heart Disease ___High Blood Pressure ___Depression/Anxiety ___Head Injury ____Cancer ____High Fevers ___Memory Issues ___Balance Concerns

If yes, when? _____ Explain _____

Physician/ENT _____ City _____ Phone _____

AMPLIFICATION HISTORY

Are you a current hearing aid wearer? ❑ Yes ❑ No Type _____ Ear fitted: ❑ Both ❑ Left ❑ Right

If yes, and you could improve something about your current hearing aids, what would that be? _____

_____

Do you know anyone who wears hearing aids? ❑ Yes ❑ No If yes, who? _____

OTOSCOPIC EXAM AND FDA QUESTIONS

Otoscopic Exam: Right Ear _____ Left Ear _____

- Visible congenital or traumatic deformity of the ear? ❑ Yes ❑ No
- Visible evidence of significant cerumen accumulation or a foreign body in the ear canal? ❑ Yes ❑ No
- Any history of, or active drainage from, the ear within the previous 90 days? ❑ Yes ❑ No
- Any history of sudden or rapidly progressive hearing loss within the previous 90 days? ❑ Yes ❑ No
- Have you experienced any acute or chronic dizziness? ❑ Yes ❑ No
- Is there a unilateral hearing loss of sudden or recent onset within the previous 90 days? ❑ Yes ❑ No
- Have you experienced any pain or discomfort? ❑ Yes ❑ No
- Audiometric air-bone gap equal to, or greater than 15dB at 500 Hz, 1000 Hz and 2000 Hz? ❑ Yes ❑ No

Hearing Care Professional _____ License #_____

WELLNESS AND ACTIVITY

1. How many distinct social settings do you find yourself in, in any given day or week?

2. What is your level of physical activity in a given day or week?

3. Has your primary care physician suggested that you increase your level of physical activity?

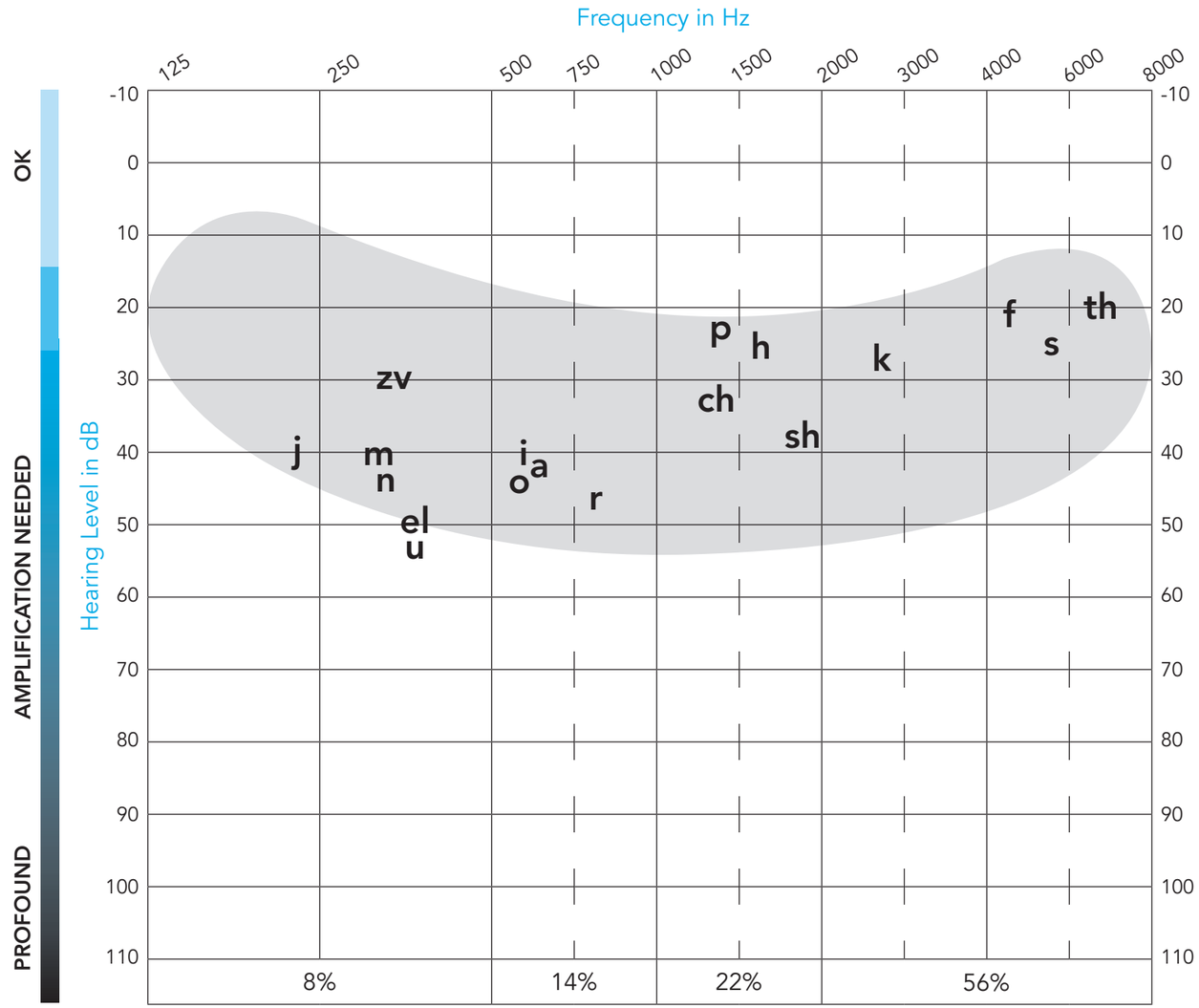
4. Which relationships in your life contribute the most to your sense of connection and well-being?

5. Do you have any concerns about balance, falling or your mobility?

6. Have you had any concerns about your memory lately?

7. Is there a family history of memory loss, dementia or Alzheimer's?

EXPLAIN AND PERFORM AUDIOMETRIC TEST



IMPORTANCE TO SPEECH INTELLIGIBILITY

SPEECH TEST RESULTS

EAR	UCL (dB HL)		MCL (dB HL)		SRT (dB HL)	WRS % CORRECT	WRS PRESENT LEVEL	
RIGHT								
LEFT								
BINAURAL	L	R	L	R			L	R

PTA (dB HL)	
L	R

Test Environment Ambient Noise Level (in dB SPL) _____

RESPONSE					
	Left	Right		Left	Right
Air Conduction Un-masked	X	O	Bone Conduction Mastoid Unmasked	>	<
Air Conduction Masked	□	△	Bone Conduction Mastoid Masked	⊐	⊏
UCL	⊓	⊓			

NO RESPONSE					
	Left	Right		Left	Right
Air Conduction Unmasked	X	O	Bone Conduction Mastoid Unmasked	≷	≷
Air Conduction Masked	□	△	Bone Conduction Mastoid Masked	⊐	⊏

Hearing Care Professional _____ License No. _____

COMMUNICATION AND NEEDS ASSESSMENT

WHAT IS GOING ON IN YOUR LIFE AROUND YOUR HEARING?

1. Who encouraged you to come see a hearing professional today? _____

2. What have you noticed about your hearing and communication with others? _____

3. What have others been saying to you about your hearing and understanding of conversations? _____

4. (To Companion) What sort of things have you noticed about his/her hearing and communication with you? With others? _____

5. What situations do you find hearing and communication most difficult for you? _____

6. Who do you find most difficult to hear and have conversations with? _____

7. What have you stopped doing because of your struggle with hearing and/or communication? _____

8. (To Companion) What situations have you observed where hearing is difficult for him/her? _____

9. (To Companion) What have the two of you stopped doing together because of his/her struggle with hearing?

HOW LONG HAS HEARING DIFFICULTY BEEN A PART OF YOUR LIFE?

1. (To Companion) How long has his/her struggles with hearing been a challenge for the two of you? _____

2. (To Patient) How long have you been aware of this communication challenge with your family and others?

COMMUNICATION AND NEEDS ASSESSMENT (CONTINUED)

CONCERN

1. (To Companion) How do his/her struggles with hearing and communication, especially between the two of you and with other family members, concern you? Please explain _____

2. (To Patient) What are your thoughts upon hearing his/her concern? In what way?

CURRENT SITUATION

1. (To Companion) You said you have been aware of his/her struggles with hearing for ___ years. Do I have that right?

2. (To Patient) You said that you have been aware of these communication difficulties for ___ years. Is that correct?

3. (To Patient) However, you did not come in ___ years ago, or ___ months ago, or even ___ weeks ago. What is it about now?

LET'S SUMMARIZE:

❑ You have told us you have struggled with hearing loss for years.

❑ You have agreed to take ownership of this visit ❑ YES ❑ NO

❑ You have shared what motivated you to come in today. _____

(To Patient), in what other environments do you find the level of communication less than you would like?

SUMMARY: PRIORITIZE ENVIRONMENTS

Rate	Difficult Listening Environments (Out of Communication)	Cost in Quality of Life (Consequence, Effect, Impact)

If I can help you hear better in environments 4, 3, 2, and especially 1, is that the result you are looking for?

EXPLANATION OF AUDIOMETRIC RESULTS

PERSONALIZED LISTENING EXPERIENCE

❑ Reference the familiar live voice tests/hearing distance assessment

HEARING INSTRUMENT SELECTION

Hearing Instrument Style _____

Verify key listening environments 1. _____ 2. _____ 3. _____ 4. _____

Given your hearing loss and the results you say you are looking for, here is what I recommend for you.

Technology_____

Features_____

Telephone Solutions_____

Accessories_____

IMPRESSIONS:

Custom Fit: To complete the process, I need to take impressions.

Open Fit: To complete the process I need to measure your ear to make sure the tube size is a perfect fit.

Ear Impression

Ear Texture: hard med soft

Canal Length: long med short

RIC/BTE

Tubing Size _____

Earbud/Size _____

Receiver Gain _____

AGREEMENT:

___ Purchase Agreement Complete

___ Present Financing Options

___ Binaural Waiver

___ Delivery Time Line

FAMILIAR/LIVE VOICE SPEECH ASSESSMENTS

Patient Name _____

Date _____ - _____ - _____

☐ Verification of Benefit Date: _____

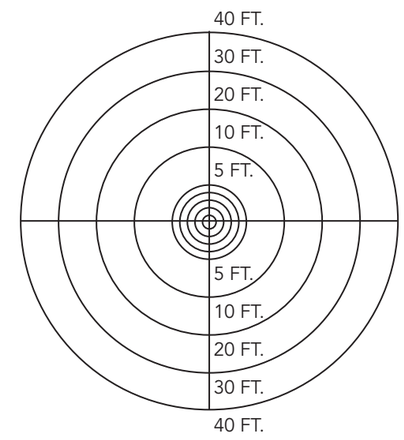
LIVE WORD LIST

Itch ☐	Say ☐	Thigh ☐	Teeth ☐
See ☐	This ☐	Sheath ☐	Seize ☐
She ☐	Shy ☐	Cheese ☐	Chase ☐
Ease ☐	Sight ☐	Cease ☐	Is ☐
Each ☐	Ace ☐	Eyes ☐	Ice ☐

Familiar/Live Voice Everyday Speech Sentences

1. Let's get a cup of coffee.
2. I hate driving at night.
3. Believe me!
4. Let's go out to eat for lunch.
5. How do you know?
6. Children like candy.
7. You can catch the bus across the street.
8. We should invite our friends over.
9. How do you spell your name?
10. Stop fooling around.
11. They're not listed in the new phone book.
12. Mother cut the birthday cake.
13. School finished early today.
14. The bath towel was wet.
15. The dog came back.
16. The shirts are hanging in the closet.
17. The train stops at the station.
18. The cat is sitting on the bed.
19. They are buying some bread.
20. He played with his train.
21. A mouse ran down the hole.
22. He cut his finger.
23. Snow falls at Christmas.
24. Milk comes in a carton.
25. A toy fell from the window.

Hearing Distance Assessment



then	else	cap	thin	carve
chew	twins	deaf	ache	bathe

After Live Personalized Listening Experience:

1. **(To Companion)** What would be the impact on your life if (patient) could hear like this? _____

   _____

2. **(To Patient)** What would be the impact on your life if you could hear like this? _____

   _____