

# PATIENT SELF-ASSESSMENT OF COMMUNICATION (SAC)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Instructions:** The purpose of this form is to identify the problems your hearing loss may be causing you. If you wear hearing aids, answer the questions according to how you communicate *when the hearing aids are in use*.

One of the five descriptions on the right should be assigned to each of the statements below.

**Select a number from 1 to 5 next to each statement (please do not answer with yes or no and pick only one answer for each question.)**

(1) Almost never (or never)

(2) Occasionally (about 1/4 of the time)

(3) About 1/2 of the time

(4) Frequently (about 3/4 of the time)

(5) Practically Always (or always)

(1) Do you experience communication difficulties in situations when speaking with one other person? (at home, at work, in a social situation, with a waitress, a store clerk, with a spouse, boss, etc.)

1	2	3	4	5
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(2) Do you experience communication difficulties while watching TV and in various types of entertainment? (movies, radio, plays, night clubs, musical entertainment, etc.)

1	2	3	4	5
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(3) Do you experience communication difficulties in situations when conversing with a small group of several persons? (with friends or families, co-workers, in meetings or casual conversations, over dinner or while playing cards, etc.)

1	2	3	4	5
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(4) Do you experience communication difficulties when you are in an unfavorable listening environment? (at a noisy party, where there is background music, when riding in an auto or bus, when someone whispers or talks from across the room, etc.)

1	2	3	4	5
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(5) How often do you experience communication difficulties in the situation where you most want to hear better?

Situation \_\_\_\_\_

1	2	3	4	5
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(6) Do you experience difficulty in hearing soft, medium, and loud environmental sounds appropriately (telephone ring, doorbell ring, traffic, horns, alarms).

1	2	3	4	5
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(7) Do you feel that any difficulty with your hearing negatively affects or hampers your personal or social life?

1	2	3	4	5
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(8) Does any problem or difficulty with your hearing worry, annoy or upset you?

1	2	3	4	5
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(9) How often do others seem to be concerned or annoyed or suggest that you have a hearing problem?

1	2	3	4	5
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(10) How often does your hearing negatively affect your enjoyment of life?

1	2	3	4	5
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(11) If you are using a hearing aid: On an average day, how many hours did you use your hearing aids?

hours \_\_\_\_\_ /16= \_\_\_\_\_ %

**Please rate your overall satisfaction with your hearing aids.**

1  not at all satisfied (0%)   2  slightly satisfied (25%)   3  moderately satisfied (50%)   \_\_\_\_\_ %  
 4  mostly satisfied (75%)   5  very satisfied (100%)

**FOR OFFICE USE ONLY**

- Pre- Assessment                       Not currently using Hearing Aids
- Post- Assessment                       Current Hearing Aid User

Score : (Q1-10) \_\_\_\_\_ (/10) \_\_\_\_\_ -1 \_\_\_\_\_ x 25 = \_\_\_\_\_ %  
 SAC - 81184 (50/pd)

# SIGNIFICANT OTHER ASSESSMENT OF COMMUNICATION (SOAC)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Person Completing Assessment: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Instructions:** The purpose of this form is to identify the problems a hearing loss may be causing your significant other. If the patient has a hearing aid, please fill out the form according to how he/she communicates *when the hearing aid is in use*.

One of the five descriptions on the right should be assigned to each of the statements below.

**Select a number from 1 to 5 next to each statement (please do not answer with yes or no and pick only one answer for each question.)**

- (1) Almost never (or never)**
- (2) Occasionally (about ¼ of the time)**
- (3) About ½ of the time**
- (4) Frequently (about ¾ of the time)**
- (5) Practically Always (or always)**

**(1) Does he/she experience communication difficulties in situations when speaking with one other person?** (at home, at work, in a social situation, with a waitress, a store clerk, with a spouse, boss, etc.)

1	2	3	4	5
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**(2) Does he/she experience communication difficulties while watching TV and in various types of entertainment?** (movies, radio, plays, night clubs, musical entertainment, etc.)

1	2	3	4	5
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**(3) Does he/she experience communication difficulties in situations when conversing with a small group of several persons?** (with friends or families, co-workers, in meetings or casual conversations, over dinner or while playing cards, etc.)

1	2	3	4	5
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**(4) Does he/she experience communication difficulties when you are in an unfavorable listening environment?** (at a noisy party, where there is background music, when riding in an auto or bus, when someone whispers or talks from across the room, etc.)

1	2	3	4	5
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**(5) How often does he/she experience communication difficulties in the situation where he/she most wants to hear better?**

Situation \_\_\_\_\_

1	2	3	4	5
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**(6) Does he/she experience difficulty in hearing soft, medium, and loud environmental sounds appropriately** (telephone ring, doorbell ring, traffic, horns, alarms).

1	2	3	4	5
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**(7) Do you feel that any difficulty with hearing negatively affects or hampers his/her personal or social life?**

1	2	3	4	5
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**(8) Do you feel that any problem or difficulty with hearing worries, annoys or upsets him/her?**

1	2	3	4	5
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**(9) Do you or others seem to be concerned or annoyed that he/she has a hearing problem?**

1	2	3	4	5
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**(10) How often does hearing loss negatively affect his/her enjoyment of life?**

1	2	3	4	5
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*FOR OFFICE USE ONLY*

- Pre- Assessment
- Post- Assessment
- Not currently using Hearing Aids
- Current Hearing Aid User

Score : (Q1-10) _____ (/10) _____ -1 _____ x 25 = _____ % SOAC - 81185 (50/pd)
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