

# Self Assessment of Communication (SAC)



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

**Instructions:** The purpose of this form is to identify the problems a hearing loss may be causing you. If you have a hearing aid, please fill out the form 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 ¼ of the time)
- 3) About ½ of the time
- 4) Frequently (about ¾ 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.)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. Do you experience communication difficulties while watching TV and in various types of entertainment? (movies, radio, plays, night clubs, musical instruments, etc.)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
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.)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
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.)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5. How often do you experience communication difficulties in the situation where you most want to hear better? <b>Situation</b> _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
6. Do you feel that any difficulty with hearing negatively affects or hampers your personal or social life?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7. Do you feel that any problem or difficulty with your hearing worries, annoys, or upsets you?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. Do you or others seem to be concerned or annoyed that you have a hearing problem?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9. How often does hearing loss negatively affect your enjoyment of life?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

10. If you are using a hearing aid: On an average day, how many hours did you use the hearing aids?  
Hours \_\_\_\_\_ /16 = \_\_\_\_\_%

Please rate what you feel is your overall satisfaction with the hearing aids.

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



# Self Assessment of Communication (SAC)



FOR OFFICE USE ONLY

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

FOR OFFICE USE ONLY

Score: (Q1-9) \_\_\_\_\_ (/9) \_\_\_\_\_ -1 \_\_\_\_\_ x25 = \_\_\_\_\_ %

Score (Q1-5)/5 = \_\_\_\_\_ (Q6-8)/3 = \_\_\_\_\_ Q9 = \_\_\_\_\_

-1x25 = D = \_\_\_\_\_ % H = \_\_\_\_\_ % Q = \_\_\_\_\_ %

