SIGNIFICANT OTHER ASSESSMENT OF COMMUNICATION (SOAC)

Name of Patient: _____ **Date:** _____

Name of Person Completing Assessment: _____ **Relationship:** _____

Instructions: The purpose of this form is to identify the problems your hearing loss may be causing your significant other. If the patient has a hearing aid, answer the questions according to how he/she communicates ***when the hearing aids are NOT 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
(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
(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
(4) Does he/she experience communication difficulties when 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
(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
(6) Do you feel that any difficulty with hearing negatively affects or hampers his/her personal or social life?	1	2	3	4	5
(7) Do you or others seem to be concerned or annoyed that he/she has a hearing problem?	1	2	3	4	5
8) Do you feel that any problem or difficulty with hearing worries, annoys, or upsets him/her?	1	2	3	4	5
(9) How often does hearing loss negatively affect his/her enjoyment of life?	1	2	3	4	5

(10) If he /she is using a hearing aid: On an average day, how many hours will he/she use the hearing aids?

Hours _____**/16=**_____**%**

Please rate what you feel is his/her 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%)

_____%

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Score: (Q1-9) _____ (/9)_____ -1 _____ x 25 = _____%

Score (Q1-5)/5=_____ (Q6-9)/4=_____ Q9=_____

-1x25= D % H % Q %