CLEARCHOICE
HEARING AND BALANCE
Sharp. Clear. Precise.

AUDITORY PROBLEM CHECKLIST

NAME_____ **DATE** _____

CLINICIAN _____

Please check all symptoms that you have had within the last year and provide details in the space provided:

___ **1. Hearing loss** _____
___ **2. Difficulty hearing when there is background noise**_____
_____
___ **3. Difficulty following conversation on the telephone** _____
___ **4. Sensitivity to loud and/or sudden noises** _____
___ **5. Difficulty comprehending rapid speech** _____
___ **6. Numbness or tingling in the face** _____
___ **7. Difficulty following long conversations** _____
___ **8. Daydreams – attention drifts – not with it at times**_____
___ **9. Easily distracted by background sound(s)**_____
___ **10. Difficulty remembering spoken information** _____
___ **11. Difficulty taking notes** _____
___ **12. Poor organizational skills** _____
___ **13. Forgetful**_____
___ **14. Difficulty in directing, sustaining or dividing attention** _____
___ **15. Difficulty recalling sequence that has been heard**_____
___ **16. Experiences difficulty following auditory directions** _____
___ **17. Frequently misunderstands what is said** _____
___ **18. Difficulty with reading and/or spelling** _____
___ **19. Learns poorly through listening** _____
___ **20. Lack of music appreciation** _____
___ **21. Talk louder than necessary** _____
___ **22. Interpret words too literally** _____
___ **23. Lacks motivation to learn** _____
___ **24. Ignore a speaker especially if preoccupied with something familiar** _____
___ **25. Difficulty learning a foreign language or vocabulary words**_____

Please answer the following question:

What is your primary symptom or difficulty
_____
_____
_____