JIAS-Questionnaire adults

Surname:	First name:	Date of birth:
Street:	Village:	
Phone number:	E-Mail:	
Questionnaire completed on:		

Questions	**Yes**	**No**
1. Problems with ear infections, tympanic effusions or other hearing problems?		
Comments:		
2. Difficulties with background noises?		
Comments:		
3. Difficulties to remember spoken information?		
Comments:		
4. Slow to respond to spoken questions?		
Comments:		
5. Hypersensitive to certain sounds or noises?		
Comments:		
6. Missunderstanding of words?		
Comments:		
7. Intonation flat / monotonous? Not good at copying tones?		
Comments:		
8. Do you suffer from tinnitus? If so, since when? In which ear? What does tinnitus sound like? (humming, rushing, whistling)? How strongly do you perceive it?		
Comments:		

Questions	Yes	No
9. Are you currently in a therapeutic treatment?		
Comments:		
10. Do you take any medication?		
Comments:		
11. Have you already had your hearing checked? If so, when? Result?		
Comments:		
12. Is your ability to concentrate impaired?		
Comments:		
13. Are you a daydreamer /absent-minder?		
Comments:		
14. Are you rather restless?		
Comments:		
15. Do you have sleeping problems?		
Comments:		
16. Do you suffer from pain? (headaches, jaw pain or back pain)		
Comments:		
17. Are you feeling stressed or burnt out?		
Comments:		
18. In which life situations does your hearing impediment impact you most?		
Comments:		
19. What is the level of suffering on a scale of: 0 (no problem) ---------- to ---------- 10 (massive suffering)		
20. Further comments:		