Aural Rehabilitation Intake: Cochlear Implant Users

CLIENT NAME: _____

DOB: _____ CHRONOLOGICAL AGE: _____

DATE FORM COMPLETED: _____

IMPLANT AUDIOLOGIST (name & contact information): _____

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1. Your Cochlear Implant

Date of implantation: _____

Ear Implanted: ____ Right ____ Left

Date of activation: _____

Do you wear a hearing aid in your opposite ear: __YES __NO

Additional hearing aid information:

- *Make/Model*_____
- *How long have you had this hearing aid?* _____
- *Beneficial? Yes? ____ No? ____ How/Why?*
  _____

INTERNAL DEVICE:

- Implant Model: _____
- Implant Serial number: _____
- Implant Manufacturer/Make: _____

EXTERNAL DEVICE:

- Processor Model: _____
- Processor Serial number: _____
- Magnet Strength: _____

Date Initially Programmed: _____

Date Last Programmed: _____

(Has any additional programming occurred?):

Processing Strategy currently in use with processor *(this information can be obtained from you implant audiologist)*: _____

Setting(s) currently in use:

- Program #_____
- Description (when / where do you use this program) _____
- Volume _____

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- Volume _____

Please provide any additional information/observations related to your programs:

2. Rehabilitation

Indicate/list any previous aural rehabilitation/therapy:

- Using Hearing Aid(s)

- Using Cochlear Implant(s)

List /Provide any post-implantation activities/therapy designed to improve hearing/listening skills: *(Provide the following if you are able to: What were **your** goals & objectives? What specifically did you work on? What was your progress? Would you change/adjust anything? If so, what/how?)*

Based on your life and daily communication, what are **your** specific listening/ communication goals?

ADDITIONAL COMMENTARY: *(please add additional page if necessary).*