Pacific Partnerships for Deaf-Blind TA Services
Functional Hearing Assessment (Draft 5/2010)

Child's Name: ______________________ DOB:_____________ DATE: __________
LOCATION:________________________________
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Sound Tester/Observer: ____

Child's Position during assessment (Sitting by self, sitting in lap, laying on floor, etc.): ______________________

Background Noise: ☐ Low (e.g., quiet room) ☐ Medium (e.g., family time) ☐ High (e.g.,

Sound		Child responds Yes/No			Distance	What did the child do?
Sound Level	Type of Sound	Behind	Right	Left		
High 80 dB +						
Medium 50 to 80 dB						
Low 50 dB -						

*Distance: score 1H = 1 hand length away or 1A =1 Arm's length away or F=Farther than 1 arm's length away.