



COSI

Client Oriented Scale of Improvement

Name: _____

Audiologist: _____

Date Pre: _____

Post: _____

☐

The patient did not return for follow-up as recommended and/or scheduled.

☐

Could not evaluate.

SPECIFIC NEEDS			
Indicate the order of significance			
DEGREE OF CHANGE			
Worse			
No Difference			
Slightly Better			
Better			
Much Better			
FINAL ABILITY (with Hearing Instrument)			
Hardly Ever 10%			
Occasionally 25%			
Half the Time 50%			
Most of the Time 75%			
Almost Always 95%			