_____ SUPPORT GROUP

Please complete this brief survey and bring it with you to the next support group meeting, or send to:

Acoustic Neuroma Association
600 Peachtree Pkwy., Suite 108
Cumming, GA 30041

1. Please let us know which category best describes you:

___**Pre-Treatment**

___**Post-Treatment** How long have you been post-treatment (in years)?____
___Surgery ___Radiation

___**Watch & Wait (no treatment)**

___**Watch & Wait (had treatment – but may need additional treatment)**
Indicate treatment type: ___Surgery ___Radiation

___If you are a **caregiver** check here and check the category above that best describes your AN partner.

2. Possible Meeting Topics

●From the list below, check up to 10 topics that most interest you for upcoming meetings.
●Of the 10 items that you checked, ***circle the three topics*** that are most important to you.

_____Alternative Therapies (Specify)_____
_____Balance Issues/Vestibular Therapy (Specify)_____
_____Caregiver Issues (Specify)_____
_____Caring and Sharing (Specify)_____
_____Coping Issues (Specify)_____
_____Dental Issues (Specify)_____
_____Eye Issues (Specify)_____
_____Facial Issues (Specify)_____
_____Fatigue and reduced stamina
_____Going back to work after AN treatment
_____Headaches (Specify)_____
_____Hearing Issues/Devices (Specify)_____

_____Memory/Cognitive Issues (Specify)_____
_____Tinnitus
_____Treatment Options (Specify)_____
_____Treatment Options for Recurring AN
_____Update on latest treatments and research
_____Other (specify)_____
_____Other (specify)_____
_____Other (specify)_____

3. Suggestions for guest speakers:

Speaker Name:_____
Topic:_____
Contact number/e-mail/location:_____

4. Comments/suggestions:

_____
_____
_____
_____
_____

Your name (optional):_____
Address (optional):_____
Phone number/Email (optional):_____

Thank you - we appreciate your feedback and comments.