Café & Restaurant Acoustic Index Rating Sheet

Name of Café/Restaurant, including City:

Date of Visit:

Your name, or name of function: (Optional):

Your Age: (compulsory!): <25 25-34 35-44 45-60 >60

How many people at your table?:

		A lot				**Not at all**
1.	How much noise do you like in cafés/restaurants?	1	2	3	4	5
2.	How much did the level of noise adversely affect your enjoyment of the dining experience?	1	2	3	4	5
3.	Did you experience any difficulties conversing with other people as a result of noise?	1	2	3	4	5
4.	How much would your experience of noise in this venue **adversely** affect your decision to return?	1	2	3	4	5
		Almost empty				**Full**
5.	How busy was the café at the time of your visit?	1	2	3	4	5
		Too Loud				**None**
6.	At what level was music playing while you were eating?	1	2	3	4	5

Send completed form to: New Zealand Acoustics, c/- PO Box 4071, Christchurch
Fax: 03 365 8477, Email: stuart@marshallday.co.nz

The New Zealand Acoustical Society

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