LSU Health Sciences Center

Speech-Language-Hearing Clinic, Department of Communication Disorders, School of Allied Health Professions, 1900 Gravier Street, 9th Floor, New Orleans, La 70112

Date: ________________________

Augmentative and Communication Case History Questionnaire

Identification

Name: ____ Birthdate: _________________Age: ______Sex:______
Address: ____
Home Phone: (_____)_____________ Cell Phone 1: (_____)_____________Cell Phone 2:(_____)_______________
Parent(s)/Guardian(s): ____
Address (if different from child): ____ Phone:(_____)_______________
Other children in family:

Name	Age	Grade	Speech-Language-Hearing or Medical Problems
________________________	_______	_______	____
________________________	_______	_______	____
________________________	_______	_______	____
________________________	_______	_______	____
________________________	_______	_______	____

Referred by: ____
Address: ____ Phone: (_____)___________________
Reason for referral:____
____
Person(s) completing questionnaire: ____
Address (if different from above): ____________________________________ Phone: (_____)___________________
Relationship to child: ____

Statement of the Problem

Please describe the communication problem fully. You may continue your description on the back of this sheet if necessary.

____
____
____
____
____
____
____
____
____

What do you expect from this evaluation?

____

____

____

Medical Information

During this pregnancy, did mother experience any unusual illnesses, conditions, or accidents, such as German Measles, Rh incompatibility, false labor, etc.? If so, please describe:

____

____

____

List any medications taken during the pregnancy.

____

Length of pregnancy: _____________ Length of labor: ______________________Birth weight: ___________________

Were there any problems with the delivery, such as breech birth, caesarean, etc.? If so please explain.

____

____

____

Conditions immediately following birth:

Did the infant have trouble starting to breath? _____ Was the infant blue? _____ Was the infant jaundiced? ________

Did the infant have sucking and/or swallowing difficulties? ______ Feeding problems? ______ Seizures? __________

Other problems?____

Check the illnesses which the child has had. Give the child's age and the severity of the illness. Please add other illnesses which the child has had but which are not listed here.

Illness	Age	Mild, Average, or Severe
Measles		
Chicken Pox		
Mumps		
Frequent cases of the flu		
Scarlet Fever		
Croup		
Tonsillitis		
Bronchitis		
Ear Infections		
Allergies		
Seizures		
Whooping cough		
Meningitis		
Encephalitis		
Other (please specify)		

Were any of the illnesses followed by noticeable changes in the child's general behavior or in his/her speech/language? ______
If so, please describe: ____

____

Has the child had any operations or surgeries?____ If so, please describe:

Surgery	Date of surgery	Physician	Hospital

Please indicate any medical diagnosis regarding the child, such as cerebral palsy, seizure disorder, etc.:
____

Type of cerebral palsy (if applicable): ____

Please list any medications the child is taking:

Medication	Dosage	Purpose	Prescribing physician

Developmental Information

When was the client able to hold his/her head alone? ____________________
Is the client currently able to sit alone without support? ____________________
If so, at what age was the child first able to do so? ____________________
Is the child able to pull up to a standing position? ____________________
If so, at what age was the child first able to do so? ____________________
Is the child able to more to desired object/toys that are out of reach? ____________________
If so, how does the child typically do so?

Rolling? ____________
Crawling? ____________
Walking? ____________

If the child walks without assistance, at what age did he/she first do so? ____________________
Does the child fall or lose balance easily? ____________________
Is the child toilet trained? ____________________
If so, at what age did child become toilet trained? ____________________
Child's present weight: ________________ Child's present height: ________________
Does the child prefer his/her right or left hand? ____________________
If the child awkward using his/her hands? ____________________
If so, please describe: ____________________
Does the child have difficulty chewing or swallowing? ____________________
Does he/she drool? ____________________

Vision

Does the child have any visual problems? Yes________ No_________

If so, please describe:

____

Date of the most recent vision test: ____

Test results: ____

Where tested?________________________________By whom?___________________________

Address: ____

(If the child has a significant vision problem, please forward us a copy of the examination report.)

Hearing

Does the child have any difficult hearing? Yes________ No_________

If so, please describe:

____

Date of the most recent vision test: ____

Test results: ____

Where tested?________________________________By whom?___________________________

Address: ____

(If the child has a significant hearing problem, please forward us a copy of the examination report.)

Cognitive Information (If applicable)

Does the child demonstrate functional object use, such as play with objects in the way that they are typically used (e.g., holds a toy telephone up to his/her ear, uses a comb for combing hair,…)?

____

If not, please describe the client's play skill by checking those actions he/she typically performs:

- Put toys in his/her mouth ______________________
- Hits toys on a surface (e.g., table top) ______________________
- Shakes toys ______________________
- Drops or throws toys on the floor ______________________
- Other (specify) ______________________

Has the client had a psychological evaluation prior to this time? __________

If so, when? ______________________Where tested? ________________________________

By whom?____

Test results? ____

(Please forward us a copy of the most recent evaluation report.)

Motor Ability

Method of mobility (please check all that apply):

- ________ Walks Unassisted
- ________ Walks Assisted
- ________ Stroller
- ________ Wheelchair

Most reliable movement patterns:

- ________ Pointing
- ________ Raising Arm
- ________ Eye Pointing
- ________ Other (specify)

____

Self-Help Skills

Does your child:

Feed self? ______ Dress self? ______ Toilet self? ______

If not, does your child require:

______ Partial assistance ______ Complete assistance

Comments: ____

Adaptive Equipment

Please check all adaptive equipment your child uses:

______ Hearing Aid ______ Wheelchair

______ Glasses ______ Communication equipment

______ Walker ______ Others (specify) ____________________________

If wheelchair is used, please describe the following:

Make: ____________________________ Model: ____________________________

Motorized: __________________________ Manual: ____________________________

Insert components: ____________________ Lap Belt: ____________________________

Chest harness: ________________________ Tray Measurements: ____________________

Activities tray is used for: ____

Social Information

Does the child currently attend any nursery school or daycare program? __________

Is so, where? ____

Does the child tend to play alone or with other children? ________________________

How the child get along with other children? ______________ With adults? ______________

What are the child's favorite activities? ______________________________________

List the places the child frequently visits:

____

List the significant people in the child's life, including name and relationship:

____

List the significant object in the child's life (toys, blankets, stuffed animals, etc)

____

Communication

Receptive Information:

Does your child seem to have trouble understanding speech? ________________________

If so, please describe: ____

____

Please indicate the child's level of understanding by checking one of the following:

__________Does not understand spoken words

__________Understands single words

__________Understands simple sentences

__________Understand 2 and 3 part commands

__________Understand conversation

(If applicable) Please list all formal receptive language testing that has been conducted and test results (to be filled out by the child's speech-language pathologist):

Tests Date given Results

____

____

____

Expressive Information:

Does the child attempt to communicate? ____________________

Does the child initiate communication? ____________________

Who does the child attempt to communicate with? ____________________

Please indicate all means of communication currently used: (If possible, rank order from most to least frequently used; 1 being most frequently used, etc.)

Speech	____________	Eye pointing	____________
Vocalization	____________	Spoken "yes-no"	____________
Manual Signing	____________	Gestural "yes-no"	____________
Bodily Gestures	____________	Communication Device	____________
Facial Expression	____________		

Spoken Communication

During the first year, other than crying would you say that the child was a:

_______silent baby? ______a very quiet baby?

______an average noisy baby? ______a very noisy baby?

At what age did the child:

Start to make cooing and babbling sounds? ____________________

Say his/her first words? ____________________

Have a name for most everything? ____________________

Use two word combinations (example "want cookie")? ____________________

Use more complex short sentences? ____________________

Did the child say one or two words and then go a long time before saying any new words? ____________

Did speech/language learning ever seem to stop for a period? ____________________

If so, please describe:

____

Does the child seem to be aware of his/her speech/language difference? ____________________

If so, please describe:

____

If the child speaks, please check if the speech is:

_______Understood by strangers

_______Understood by family/friends only

_______Difficult for family/friends to understand

_______Is never understood by others

What percentage of the child's speech are you able to understand?

_______100% _______75% _______50% _______what%

If the child is not understood, is he/she"

_______Quickly discouraged _______Persistent

_______Frustrated _______Apathetic

Has the child ever spoken better than he/she does now? _______________

How many words are in the child's average message?

_______One word
_______Two to three words
_______Four to five words
_______Five or more words

Unaided Communication (if applicable) – The use of gestures, manual signs...in which the child does not rely on the use of any external communication equipment.

Please indicate the type of unaided communication systems currently used by checking the following:

______Natural gestures (handshake for <u>no</u>, pointing)
______Signing Exact English
______Duffy's Innovative
______Sign System
______Finger Spelling
______Other (please specify) ________________________
______Pantomime
______Amer-Ind Gestural Code
______American Sign Language
______Signed English
______Cued Speech

How many signs/gestures are in the child's average message?

_______One
_______Two to three
_______Four to five
_______Five or more

Approximately how many gestures/manual signs does the child currently use spontaneously (i.e., on his/her own initiative without cueing) to communicate?* ____

Aided Communication (if applicable) – The use of communication boards, electronic devices…in which the child relies on the use of some type of communication equipment.

Please describe the type of aided communication system/device currently used:

____

____

How long has the client been using the device described? ____

Please list all communication systems use in the past and check whether the system proved successful or unsuccessful.

System	Successful	Unsuccessful
________________________________	________	________
________________________________	________	________
________________________________	________	________
________________________________	________	________

How are vocabulary items represented on the child's present communication board/device? (check all that apply)

_____ Photographs
_____ Color pictures
_____ Line drawings
_____ Oakland School Pictures
_____ Core Picture Vocabulary
_____ Talking pictures
_____ Touch 'N Talk stickers
______ Picture communication symbols
______ Rebus symbols
______ Pic symbols
______ Picsyms
______ Blissymbols
______ Letters
______ Other (specify) ___________________________

* Please attach a listing of these gestures/manual signs.

What is the size of the pictures/symbols representing the vocabulary items? (Example: 1 inch square)

____

How many vocabulary items are displayed on the client's device?† ______________________________

The child primarily uses these items:

______ Imitatively

______ In response to questions

______ In response to commands (Example: "Show me what you want.")

______ Spontaneously (i.e., on his/her own initiative without cueing)

If using a non-electronic communication aid/device such as a homemade communication board, how many vocabulary elements/symbols are in the client's average message?

_______One

_______Two to three

_______Four to five

_______Five or more

If using an electronic communication aid/device with voice output, what is the length of the programmed/recorded message? ____

Therapy History

List all therapy programs/services the child has been enrolled in:

Type of Therapy | Therapist | Address | Phone | Dates Enrolled

____

____

____

____

____

If presently seen for therapy by a speech-language pathologist, please provide information regarding current therapy goals and intervention (to be filled out by the child's speech-language pathologist).

____

____

____

Support Services

Probable/current communication interventionist:

Name: ____

Address: ____Phone: ____________________

Indicate agencies for possible financial assistance:

_____ Medicaid _____ Medicare

_____ Private insurance _____ Service group

_____ SSI _____ Church group

_____ Other

† Please attach a listing of the vocabulary items displayed in the child's communication aid. Star (*) those items the child is currently using spontaneously.

Additional Information

If there is additional information which you feel will help us to understand the child and his/her problem better, please describe:

____
____
____
____
____

Please attach a picture of the child positioned in seating typically used for everyday activities.

Please print name of person completing the case history ____________________________________

Date ________________________