LSU Health Sciences Center

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

Date: _____

Augmentative and Communication Case History Questionnaire - Adult

Identification

Name: _____ Birthdate:_____Age:_____Sex:_____
Address: _____
Home Phone: (_____)_____ Cell Phone 1: (_____)_____Cell Phone 2:(_____)_____
Parent(s)/Spouse: _____
Address: _____ Phone:(_____)_____
Referred by: _____
Address: _____ Phone: (_____)_____
Reason for referral:_____
_____
Person(s) completing questionnaire: _____
Address (if different from above): _____ Phone: (_____)_____
Relationship to individual: _____

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

Medical diagnosis (check all that apply and indicate date of onset):

_____Cerebral Palsy (type_____)
_____Aphasia
_____Dysarthria
_____Apraxia
_____Amyotrophic lateral sclerosis (ALS)
_____Seizure disorder
_____Muscular Dystrophy
_____Laryngectomy
_____Cognitive Disorders
_____Autism
_____Multiple sclerosis
_____Other (specify)_____
_____

Medical condition: _____Stable _____Progressive

Physician's name:_____

Address: _____Phone: (_____)_____

Please indicate any medication currently used, the dosage, purpose and prescribing physician (if applicable):

Medication	Dosage	Purpose	Prescribing physician

Vision

Does the individual 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 individual has a significant vision problem, please forward us a copy of the examination report.)

Hearing

Does the individual 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 individual has a significant hearing problem, please forward us a copy of the examination report.)

Cognitive Information (If applicable)

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

If so, date of most recent evaluation:

_____Test results?

_____

Where tested? _____

By whom?_____

Address: _____

(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 the individual:

Feed self? _____ Dress self? _____ Toilet self? _____

If not, does theindividualrequire:

_____ Partial assistance _____ Complete assistance

Comments: _____

Academics (if applicable)

Highest academic level completed: _____

If the individual still attends school, please provide the following:

Present grade: _____ Type of class: _____

Reading level: _____ Spelling level: _____

Math level: _____ Writing proficiency: _____

Can the individual (check all that apply):

Match objects: _____ Match colors: _____

Match shapes: _____ Match numbers: _____

School Name: _____

Address: _____Phone: (_____)_____*

Teacher's name: _____

Employment (if applicable)

Present employment status: _____

Employer: _____

Job description: _____

* Please include a copy of the individual's most recent report card. (if applicable)

Environment

Place of residence:

_____Private family dwelling

_____Nursing home

_____Other _____

_____Group home

Persons at the residence: _____

What percentage of a typical day is the individual at:

_____Home _____Work _____School _____Other

What percentage of a typical day is the individual:

_____In a wheelchair

_____In chair

_____In bed

_____With walker

_____On floor

_____Side lying

_____Other _____

List places the individual frequently visits:

_____

List significant people in the individual's life:

_____

List significant objects in the individual's life:

_____

List significant activities in the individual's life:

_____

Adaptive Equipment

Please check all adaptive equipment your individual uses:

_____ Hearing Aid

_____ Glasses

_____ Walker

_____ Wheelchair

_____ Communication equipment

_____ 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: _____

Communication

Receptive Information:

Does your individual seem to have trouble understanding speech? _____

If so, please describe: _____

_____

Please indicate the individual'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 individual's speech-language pathologist):

Tests	Date given	Results

Expressive Information:

Does the individual attempt to communicate? _____
Does the individual initiate communication? _____
Who does the individual 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

If the individual 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 individual's speech are you able to understand?

_____100% _____75% _____50% _____what%

If the individual is not understood, is he/she:

_____Quickly discouraged _____Persistent
_____Frustrated _____Apathetic

Has the individual ever spoken better than he/she does now? _____
How many words are in the individual'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 individual 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 no, pointing)
_____Signing Exact English
_____American Sign Language
_____Signed English
_____Cued Speech
_____Other (please specify) _____
_____Pantomime
_____Amer-Ind Gestural Code
_____Sign System
_____Finger Spelling

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

_____One
_____Two to three
_____Four to five
_____Five or more

Approximately how many gestures/manual signs does the individual 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 individual 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 individual'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) _____

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?‡ _____

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

The individual 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 individual 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 individual'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 individual and his/her problem better, please describe:

_____
_____
_____
_____
_____

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

Please print name of person completing the case history _____

Date _____