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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Grade</th>
<th>Speech-Language-Hearing or Medical Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Illness</th>
<th>Age</th>
<th>Mild, Average, or Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent cases of the flu</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scarlet Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Croup</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tonsillitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear Infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whooping cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encephalitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Date of surgery</th>
<th>Physician</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Purpose</th>
<th>Prescribing physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 objects/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 the 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 is 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)

Page | 4
**Self-Help Skills**

Does your child:


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):

<table>
<thead>
<tr>
<th>Tests</th>
<th>Date given</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 no, pointing)
- Signing Exact English
- Duffy’s Innovative
- Sign System
- Finger Spelling
- Other (please specify)

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.

<table>
<thead>
<tr>
<th>System</th>
<th>Successful</th>
<th>Unsuccessful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:
<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th>Therapist</th>
<th>Address</th>
<th>Phone</th>
<th>Dates Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 __________________________