Simplified Speech Solutions, LLC

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Client Questionnaire Form for Augmentative Alternative Communication Evaluation

Client Information	
Today's Date:	**Person Completing Questionnaire:**
Client Name:	**Relationship to Client:**
Date of Birth:	

Parent/Guardian Information	
Name:	**Home Phone:**
Email:	**Cell Phone:**
Address:	

Medical Information	
Medical Diagnosis:	**Communication Diagnosis:**
Hearing: **Has the client's hearing been tested? ☐Yes ☐ No** **When:** **Where:** **Results:** **Does the client wear hearing aids, use an FM system or have a cochlear implant? ☐ Yes ☐ No**	**Vision:** **Has the client's vision been tested? ☐Yes ☐ No** **When:** **Where:** **Results:** **Does the client wear glasses? ☐ Yes ☐ No**
Does the client have seizures? ☐ Yes ☐ No **If yes, please specify the type and frequency:**	

Educational/ Facility Setting			
School/Facility Name:		**Contact Person/Case Manager:**	
Address:		**Email address:**	
Phone Number:		**Grade (If applicable):**	
Special Education Services: (fill in all that apply)			
Type of Therapy	**Number of Sessions x mins/ week**	**Type of Therapy**	**Number of Sessions x mins /week**
Speech Therapy		**Occupational Therapy**	
Physical Therapy		**Special Education**	
Other:			

Communication

Does the client currently: (Check all that apply)

- ☐ Understand simple directions? Example:
- ☐ Understand name for people and objects?
- ☐ Understand names of body parts?
- ☐ Answer simple questions? Example:
- ☐ Understand prepositions (in, under, on)?
- ☐ Understand Color and Size words?

Which of the following describe(s) how the client currently communicates? (Check all that apply)

- ☐ Pointing, gesturing
- ☐ Eye contact
- ☐ Pulls person to desired object/location
- ☐ Objects/tangible items
- ☐ Communication board/books
- ☐ Single Words
- ☐ Sentences with some errors
- ☐ Communication device (if yes see page 3)
- ☐ Other (please specify):
- ☐ Vocalizing
- ☐ Facial Expressions
- ☐ Babbling
- ☐ Pictures
- ☐ Sign language
- ☐ Two word phrases
- ☐ Writing

If the client uses communication boards/books to communicate, please provide additional information below:	
Symbol Type: (check all that apply) ☐ Text ☐ PECS (Picture Exchange Communication System) ☐ Mayer Johnson PCS ☐ Photographs ☐ Objects ☐ Other	**Number of Symbols per page:** **Number of pages in book:** **Presentation:** ☐ Removable Icons ☐ Static Grid **Access:** ☐ Point ☐ Symbol Exchange ☐ Other:
What is the purpose of the client's communication: (Check all that apply) ☐ Ask for wants/needs? ☐ Get attention? ☐ Label people, things, or pictures around him/her? ☐ Ask questions? ☐ Greet people? ☐ Ask for help? ☐ Share Information?	**What does the client do when not understood? Please explain (e.g. repeat message, modifies message, stops communicating, etc.):**
If the client speaks, do you have difficulty understanding his/her speech? If yes, please explain:	**Do others have difficulty understanding his/her speech? If yes, please explain.**

Please complete if the client is using/has used a communication device.
History of device use **Name of device (s) :** **Age of device:** **Is the device currently being used? Yes /No** **If no, please explain why:**
Environments where device is used: (check all that apply) ☐ Structured school activities ☐ In therapy ☐ At home during structured tasks ☐ Spontaneously at home for social interactions ☐ Spontaneously in the community/school
Access: (check all that apply) ☐ Direct selection (touch screen) ☐ Keyguard ☐ yes ☐ no ☐ Joy stick ☐ Head mouse ☐ Scanning ☐ Eye gaze If yes: Type of switch Number of switches Type of scanning ☐ Other:

Physical Status

Gross Motor Status:

- ☐ Walks independently
- ☐ Walks using assistive device (i.e. crutches, walker, cane)
- ☐ Can walk short distances with physical assistance of another person
- ☐ Unable to walk

Fine Motor Status:

- ☐ Has no problem using both hands for feeding, writing, etc
- ☐ Has functional use of left hand only
- ☐ Has functional use of right hand only
- ☐ Has great difficulty functionally using hands
- ☐ Can write for short periods of time
- ☐ Can isolate a finger or thumb to activate a 1 inch target
- ☐ Other (please specify):

Positioning Assisted Transportation:

- ☐ Uses a stroller which is pushed by someone
- ☐ Uses a wheelchair which is pushed by someone
- ☐ Propels a manual wheelchair themselves
- ☐ Drives a power wheelchair
  If yes, please indicate how the client drives the chair (i.e. joy stick, head switch array, etc.)
- ☐ Stander
- ☐ Walker or gait trainer
- ☐ Other:

Please list make and model of wheelchair or stroller:

Can easily control movements of :

☐ Eyes	☐ Head	☐ Right hand	☐ Left hand
☐ Left foot	☐ Right foot	☐ Other body part ________________	

☐ Adaptive access ☐ The client does not independently access the computer.

Behavior

Describe typical behavior:	**List preferred toys, foods, songs, videos, etc.**
How long will client attend to an activity he/she is interested in?	**Does client exhibit any aggressive/self injurious behaviors?** ☐ Yes ☐ No **If yes, is he/she currently receiving behavioral intervention?** ☐ Yes ☐ No

Goals of Evaluation
What is/ are your desired outcome(s) for the client following this evaluation?
Additional Comments: