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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	
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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. |
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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:

