AAC Intake Questionnaire

General Information

Client Name:_____
Date of Birth:_____
Medical Diagnosis:_____
Language(s) Spoken at Home:_____
Person Completing Questionnaire:_____
Relationship to Client:_____
Parent Name(s):_____
Home Address:_____
Work:_____ Cell:_____ E-Mail:_____
Client lives with:_____
Languages spoken at home:_____
Any custodial or guardianship information that we should be aware of?

_____
School and Grade_____
My child participates in the following services at SCHOOL:

- ❑ Speech Therapy
- ❑ Occupational Therapy
- ❑ Physical Therapy
- ❑ Vision Services
- ❑ Behavioral Services
- ❑ 1:1 Paraprofessional Support
- ❑ Shared Paraprofessional Support
- ❑ Other:_____

My child participates in the following services PRIVATELY or AT HOME:

- ❑ Speech therapy
- ❑ Occupational Therapy
- ❑ Physical Therapy
- ❑ Vision services
- ❑ Behavioral Services
- ❑ Other:_____

PLEASE LIST ANY SPECIFIC QUESTIONS YOU WOULD LIKE ANSWERED AS PART OF THIS EVALUATION:

_____
_____
_____

HEALTH INFORMATION

Medical Diagnoses:

Any feeding and swallowing concerns?

Please list any medications your child is taking.

Please check all that apply:

Vision:

- ❑ Has been screened/evaluated, no concerns
- ❑ Wears glasses
- ❑ Cortical Vision Impairment
- ❑ Other information:_____
- ❑ Unknown

Hearing

- ❑ Has been screened/evaluated, no concerns
- ❑ Has history of ear infections
- ❑ Has hearing impairment, please specify:_____
- ❑ Wears Hearing Aids ____L ____R
- ❑ Cochlear implant ____L ____R

MOTOR INFORMATION

My child's dominant side is the ____left ____right ____unknown ___uses both

Does your child use splints, vests, switches or other adaptive equipment? Yes If yes, please specify:

Please check the form(s) of mobility that your child uses (check all that apply):

- ❑ ambulatory without assistance
- ❑ independent ambulation with assistive device (e.g., walker)
- ❑ ambulatory for short distances with assistive device (e.g., walker)
- ❑ independent use of manual wheelchair
- ❑ independent use of power wheelchair
- ❑ dependent on someone else to push manual wheelchair

If your child has a wheelchair, please indicate the type and model.

EXPRESSIVE LANGUAGE

My child uses the following modes of communication (*check all that apply*):

- ❑ Speech-single words
- ❑ Speech-full sentences
- ❑ Speech is difficult to understand
- ❑ Echolalia/clipping
- ❑ vocalizations
- ❑ eye gaze
- ❑ hand gestures (e.g., wave, thumbs-up)
- ❑ sign language
- ❑ body language
- ❑ pointing or leading to an object
- ❑ communication board or book
- ❑ electronic device
- ❑ yes/no signal
- ❑ writing/spelling
- ❑ other: _____

Using the modes of communication listed above, my child is able to successfully perform the following communicative functions (*check all that apply*):

- ❑ socialize
- ❑ make requests (e.g., I want ice cream)
- ❑ answer yes/no questions (e.g., Do you want chocolate?)
- ❑ answer choice questions (e.g., Which one do you want, vanilla or chocolate?)
- ❑ answer open ended questions (e.g., What flavor do you want?)
- ❑ indicate basic needs (e.g., I'm hungry.)
- ❑ offer information (e.g., At school we went on a field trip.)
- ❑ ask questions (e.g., Where are we going?)

Has your child ever used an augmentative communication system? ___yes ___no

If yes, please describe.

PREFERRED ACTIVITIES

Please check those items/activities that your child enjoys most:

- ❑ TV: Any favorite shows or characters?_____
- ❑ iPad/Computer: Any favorites? _____
- ❑ Music: Any favorites? _____

- ❑ Books
- ❑ Coloring/Drawing
- ❑ Puzzles
- ❑ Other: _____