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 custody or guardianship information that we should be aware of?

____

School and Grade

____

SCHOOL Services:

❏ Speech Therapy

❏ Occupational Therapy

❏ Physical Therapy

❏ Vision Services

❏ Behavioral Services

❏ 1:1 Paraprofessional Support

❏ Shared Paraprofessional Support

❏ Other:____

PRIVATELY or HOME Services:

❏ 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:

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

Dominant side is the ____left ____right ____unknown ___uses both

Please list any adaptive equipment being used such as splints, vests, or switches. Yes If yes, please specify:

Please check the form(s) of mobility that in use (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

Please indicate the type and model of wheelchair:

EXPRESSIVE LANGUAGE (*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, language is used for these 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 the individual used an augmentative communication system? ___yes ___no

If yes, please describe.

PREFERRED ACTIVITIES Please check those items/activities that the individual enjoys most:

- ❏ TV: Any favorite shows or characters?__________________________
- ❏ iPad/Computer: Any favorites? _______________________________
- ❏ Music: Any favorites? _____________________________________
- ❏ Books
- ❏ Coloring/Drawing
- ❏ Puzzles
- ❏ Other: ____