

**UNIVERSITY SPEECH, LANGUAGE AND HEARING CLINIC:  
A UNITED WAY FACILITY**

**COMMUNICATION ENHANCEMENT GROUP  
AUGMENTATIVE/ALTERNATIVE COMMUNICATION SPECIALTY CLINIC**

**CASE HISTORY FORM**

*Instructions*

Please fill out this form in as much detail as possible. You can be assured that this information will be treated as confidential. If information is not available, please specify the reason so that we will know that the question has been considered. **Please return this form prior to your appointment.** Thank you.

Date: \_\_\_\_\_

Name of person completing information: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Client name: \_\_\_\_\_ Gender: M F

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone #: (H) \_\_\_\_\_ (Alt.) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Physician: \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

With whom does the client reside-please provide name and relation: \_\_\_\_\_  
\_\_\_\_\_

Please check one:

Client's general health: \_\_\_\_\_ excellent \_\_\_\_\_ fair \_\_\_\_\_ poor  
Client's physical endurance: \_\_\_\_\_ excellent \_\_\_\_\_ fair \_\_\_\_\_ poor  
Feeding: \_\_\_\_\_ oral intake \_\_\_\_\_ feeding tube

Current Medications: \_\_\_\_\_

Seizure activity: \_\_\_\_\_ yes \_\_\_\_\_ no

**NOTE: To be filled out by client's current speech-language pathologist; or person working on communication if communication specialist is not available.**

\_\_\_\_\_ has been referred to the Augmentative/Alternative Communication Specialty Clinic at The University Speech, Language and Hearing Clinic. Your input is valued and necessary for a thorough assessment. We appreciate the time and effort involved in completing this form.

Service Provider (i.e., speech-language pathologist)

Name and Title: \_\_\_\_\_

Facility and Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

How long have you worked with this client? \_\_\_\_\_

Indicate the current service delivery model (ind/group) used with this client including frequency and duration:

\_\_\_\_\_

Please describe client's current means of communication. (Please be specific)

\_\_\_\_\_

\_\_\_\_\_

Does this person have a means to indicate "yes" or "no"? If so, please describe: \_\_\_\_\_

\_\_\_\_\_

Describe how this client does the following: (Use the back if needed)

Gains attention: \_\_\_\_\_

Request something: \_\_\_\_\_

Comments on something he/she sees or does: \_\_\_\_\_

Asks for "more"? \_\_\_\_\_

Do you think this client can understand much more than she/he can say (produce)? Y / N

If yes, why? \_\_\_\_\_

Do you think this client gets frustrated when they cannot communicate effectively? Y/N

If yes, why? \_\_\_\_\_

Can the client match: (circle all that apply)

object to object ---- object to photo ---- object to picture

object to line drawing ---- picture to photo ---- picture to line drawing

Circle all items which the client can identify (by pointing or looking) when named:

Objects          Photos          Pictures          Line Drawings          Written Words

What are current therapy goals for this client? \_\_\_\_\_

\_\_\_\_\_

If significantly different from previous goals, please describe previous goals and why they were changed: \_\_\_\_\_

\_\_\_\_\_

Does the person exhibit motor speech disorders?

Dysarthria: yes \_\_\_\_\_ type \_\_\_\_\_ no \_\_\_\_\_ not sure \_\_\_\_\_

Apraxia: yes \_\_\_\_\_ type \_\_\_\_\_ no \_\_\_\_\_ not sure \_\_\_\_\_

Please summarize results of this client's most recent speech and language evaluation:

Language Comprehension

Test or informal procedures

results

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Language Production

Test or informal procedures

results

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Speech Production

Test or informal procedures

results

\_\_\_\_\_

\_\_\_\_\_

Behavioral Observations

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate the person's level of intellectual functioning and the test/s used in that determination:

Results of the formal test: \_\_\_\_\_

Your impression: \_\_\_\_\_

Client's classroom performance: (Please describe if applicable.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE COMPLETE THIS SECTION IF CLIENT IS CURRENTLY USING AN AUGMENTATIVE COMMUNICATION SYSTEM**

Why was an augmentative system introduced? \_\_\_\_\_

\_\_\_\_\_

Describe the augmentative system: \_\_\_\_\_

Why was this particular system chosen? \_\_\_\_\_

How long has the client been using the system? \_\_\_\_\_

When using the AAC system, how does the client indicate the choices he/she wishes to communicate?

Direct selection using: \_\_\_\_\_ finger \_\_\_\_\_ headstick \_\_\_\_\_ eye gaze \_\_\_\_\_ other

If using an electronic aid, what type of switch or control mechanism is being used and/or how does the client operate it? \_\_\_\_\_

If using signing, in your opinion, how adequate is their motor control for signing? \_\_\_\_\_

Has the client's speech improved since introduction of an augmentative aid? If yes, please elaborate. \_\_\_\_\_

Who has been the primary person responsible for layout &/or programming of the communication aid? (i.e. creating pictures, programming device, etc.) \_\_\_\_\_

Who has been responsible for purchasing the materials and/or the communication device? \_\_\_\_\_

Is this system used outside of therapy? Y / N If so, where? \_\_\_\_\_

**PLEASE USE THE BACK OF THIS PAGE TO DESCRIBE ANY PROBLEMS ENCOUNTERED WITH THE SYSTEM DESCRIBED ABOVE.**

Does the client use his/her communication system to:

Initiate Communicative Interaction?	YES	NO
Ask Questions?	YES	NO
Respond to questions?	YES	NO
Reject things?	YES	NO
Comment to people?	YES	NO
Comment on future events/requests?	YES	NO
Make requests for people?	YES	NO
Make requests for objects?	YES	NO
Request for activities?	YES	NO
Complete school work?	YES	NO
Initiate social interactions?	YES	NO
Elaborate on own utterances?	YES	NO
Elaborate on others utterances?	YES	NO

What is your purpose for this evaluation? \_\_\_\_\_

What do you hope to gain from speech-language therapy? \_\_\_\_\_

---

---

**PLEASE MAKE A SKETCH OF THIS INDIVIDUAL'S CURRENT COMMUNICATION SYSTEM ON THE BACK OF THIS PAGE, IF APPLICABLE.**

Signature of person completing this form: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to client (if applicable): \_\_\_\_\_

**AAC ADDENDUM: FOR ADULT CLIENTS**

To be completed by client, client's primary caregiver or other significant person involved with the client.

Client's name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**EDUCATIONAL HISTORY**

Educational level: \_\_\_\_\_ Degree or area of specialty: \_\_\_\_\_

Academic performance (specify strengths/weaknesses):

\_\_\_\_\_  
\_\_\_\_\_

**EMPLOYMENT HISTORY**

Occupation: \_\_\_\_\_

Place of employment: \_\_\_\_\_

Years employed: \_\_\_\_\_

Are you currently employed? \_\_\_\_\_ If yes, please specify the type of work in which you participate. If no, please indicate the reason for unemployment.

\_\_\_\_\_  
\_\_\_\_\_

What are your plans for future employment? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you want to enhance your communication skills to improve your ability to gain employment or to advance in your current position? If yes, please specify. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**NAME OF PERSON COMPLETING THIS FORM:** \_\_\_\_\_

**RELATIONSHIP TO CLIENT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM. PLEASE RETURN THIS FORM WITH THE COMMUNICATION INTAKE FORM.**

**AAC ADDENDUM: FOR CHILDREN AND YOUNG ADULTS**

To be completed by client's primary caregiver.

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

| SCHOOL & DISTRICT: \_\_\_\_\_

**FAMILY INFORMATION:**

Father:

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Is he living with the family? \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employed by: \_\_\_\_\_  
Educational level: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

| Mother:

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Is she living with the family? \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employed by: \_\_\_\_\_  
Educational level: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

1. Name three activities that you and your child enjoy doing together: \_\_\_\_\_

\_\_\_\_\_

2. How does your child tell you that he/she wants something?

\_\_\_\_\_

3. How does your child get your attention? \_\_\_\_\_

4. If your child could clearly convey three messages, what do you wish they could be?

\_\_\_\_\_

5. Do you think your child can understand more than he/she can express? If yes, please give some examples.

\_\_\_\_\_

6. What motivates your child? What makes your child happy and serves as a reward?

\_\_\_\_\_

NAME OF PERSON COMPLETING THIS FORM: \_\_\_\_\_ -  
RELATIONSHIP TO CHILD: \_\_\_\_\_ Date: \_\_\_\_\_