AAC Intake Questionnaire

General Information

Client Name _____

Date of Birth _____

Medical Diagnosis_____

Language(s) Spoken at Home _____

Name of Person Completing Questionnaire _____

Relationship to Client _____

Parent Name(s) _____

_____

Home Address _____

_____ Phone Number(s) Home: _____

Work: _____ Cell: _____ E-Mail _____

FAMILY

List all children and their ages in your family:

_____ _____

_____ _____

_____ _____

_____ _____

How does your child interact with his/her siblings?

Describe your child's personality:

Is there any family history of speech or learning difficulties? ☐ Yes ☐ No

If yes, please explain:

BIRTH HISTORY

Were there any complications during pregnancy or birth? ☐ Yes ☐ No

If yes, please explain:

HEALTH INFORMATION

Has your child had any unusual health incidents? ☐ Yes ☐ No

If yes, please explain:

Has your child had frequent ear infections? ☐ Yes ☐ No

Has your child had surgery in the past year? ☐ Yes ☐ No

If yes, please explain:

Is your child scheduled to have a surgical procedure in the near future?

If yes, please explain: ☐ Yes ☐ No

Please list any medications your child is taking.

SENSORY INFORMATION (Check Appropriate Boxes)

Has your child had any professional testing in the following areas:

Vision ☐ Yes ☐ No

Hearing ☐ Yes ☐ No

Hearing ☐ functional for needs ☐ hearing aids: right/left/bilateral

☐ not functional for needs (specify _____)

☐ unknown

Vision ☐ functional for needs ☐ corrected: glasses/contact lenses

☐ not functional for needs (specify _____)

☐ unknown

Tactile ☐ functional for needs ☐ bothered by touch*

☐ under-responsive to touch

*If your child is bothered by touch, please specify which textures (s)he likes the best and which textures are difficult to tolerate.

MOTOR INFORMATION

When was your child:

sitting alone? _____ crawling? _____

walking? _____ toilet trained? _____

My child's motor coordination is ☐ good for age ☐ clumsy for age

If clumsy, please explain:

My child's dominant side is the ☐ left ☐ right ☐ unknown

Please check the part(s) of the body that your child can use purposefully:

☐ head ☐ hand: right/left

☐ arm: right/left ☐ leg: right/left ☐ foot: right/left

☐ other (specify body part(s) _____)

Does your child use splints, vests or other adaptive equipment? ☐ Yes ☐ No

If yes, please specify:

Please check the your child's level of independence in the following daily living activities:

	Independent	Requires Assistance	Dependent on Caregiver
Dressing	☐	☐	☐
Bathing	☐	☐	☐
Toileting	☐	☐	☐
Eating	☐	☐	☐

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 (specify how your child controls the chair).

RECEPTIVE LANGUAGE (Check All That Apply)

My child *understands*:

☐ single words ☐ phrases
☐ sentences ☐ conversation
☐ one-step directions (e.g., sit down, stop)
☐ yes/no questions
☐ choice questions
☐ wh- questions (e.g., where, when, who)

EXPRESSIVE LANGUAGE

When did your child:

babble? _____ say his/her first word? _____

combine 2 words? _____ use complete sentences? _____

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

☐ speech
  ☐ words (about how many _____)
  ☐ sentences
☐ vocalizations
☐ eye gaze
☐ hand gestures (e.g., waive, thumbs-up)
☐ sign language (how many signs _____)
☐ body language
☐ pointing or leading to an object
☐ communication board or book
☐ electronic device
☐ other (specify _____)

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?)

When your child uses his/her speech to communicate, what percentage of his/her messages can be understood by familiar communication partners (e.g., family members)?

☐ 0%-25% ☐ 26%-50% ☐ 51%-75% ☐ 76%-100%

When your child uses his/her speech to communicate, what percentage of his/her messages can be understood by unfamiliar communication partners (e.g., people in the community)?

☐ 0%-25% ☐ 26%-50% ☐ 51%-75% ☐ 76%-100%

Does your child's speech volume or clarity fluctuate throughout the day?

If yes, please explain: ☐ Yes ☐ No

Has your child ever used an augmentative communication system?

☐ yes ☐ no

If yes, please describe.

What concerns do you have about your child's speech and language?

**** Please provide copies of current speech-language evaluation reports, progress notes, and speech-language IEP goals.***

LITERACY

☐ My child is not yet able to read or write.

My child is able to recognize:

☐ letters ☐ sight words ☐ sentences ☐ paragraphs

My child is able to functionally read:

☐ letters ☐ sight words ☐ sentences ☐ paragraphs

My child is able to produce by handwriting:

☐ letters ☐ words ☐ sentences ☐ paragraphs

My child is able to produce by typing:

☐ letters ☐ words ☐ sentences ☐ paragraphs

PREFERRED ACTIVITIES

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

☐ TV ☐ books ☐ puzzles ☐ iPad ☐ arts & crafts

☐ bubbles ☐ food (specify favorite foods _____)

☐ music ☐ play-doh ☐ blocks ☐ Mr. Potato Head ☐ swing

☐ other (specify _____)

ADDITIONAL COMMENTS