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AUGMENTATIVE AND ALTERNATIVE COMMUNICATION (AAC) EVALUATION ADULT CLIENT APPLICATION FORM

TODAY'S DATE:

IDENTIFYING INFORMATION:

Name of person filling out this form: **Pronouns:** **Email address:**

Name of person to be evaluated/client (if different from above): **Pronouns:**	
Address: _____ _____ _____	Phone: Home _____ Cell _____ Work _____
Email:	Age:
Date of Birth:	
Occupation:	
Language Dominance:	
Other Languages Spoken in the home:	
Client lives with:	

Name of client's spouse if applicable:	Age:

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503 Behrakis Health Science Center Boston, MA 02115
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Medical Diagnoses:

If client is under 21 and/or living with parents/guardians:

Parent/Guardian #1 Name:	
Address: _____ _____ _____	Phone: Home _____ Cell _____ Work _____
Parent/Guardian #2 Name:	
Address: _____ _____ _____ ☐ Check if same as above	Phone: Home _____ Cell _____ Work _____

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REASON FOR REFERRAL/REQUEST:

Who referred the client?	Position/Relationship to client:
Reason for referral:	
List any specific questions you would like answered as part of this evaluation:	
What are your and the referring person's primary goals for this evaluation?	

What cultural practices, rituals, or beliefs do you believe are important for us to be aware of?

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Has the client had a speech and language or Augmentative and Alternative Communication Evaluation at any other clinic? ☐ Yes ☐ No	
If yes, please list those that occurred in the last **five years**:	
Name of clinic:	Date of evaluation:
Address:	
Name of clinic:	Date of evaluation:
Address:	
Name of clinic:	Date of evaluation:
Address:	

Has the client ever used an AAC device or low/no tech systems including symbols?		
If yes, please list all devices that have been used and the dates they were in use:		
AAC device/system	Dates used	Was it useful?

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Has the client received prior **Speech Therapy** services?	☐ Yes	☐ No
If yes, please list the most recent dates of service:		
Name of Clinic:	Therapist's Name:	
What was most helpful with these services?		
What was least helpful with these services?		
Has the client received **ABA Therapy**?	☐ Yes	☐ No
If yes, please list the most recent dates of service:		
Name of Clinic:	BCBA's Name:	
What was most helpful with these services?		
What was least helpful with these services?		
Has the client received **Occupational Therapy**?	☐ Yes	☐ No
If yes, please list the most recent dates of service:		
Name of Clinic:	OT's Name:	
What was most helpful with these services?		
What was least helpful with these services?		

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How would you describe the client's overall development in early childhood (e.g., meeting development milestones, walking, talking, crawling, etc.)?
Strengths of the client:
Areas of support provided to the client:
What do you envision for the client over the next 5 years?

MOTOR INFORMATION

Client's dominant side is the ☐ left ☐ right ☐ unknown ☐ uses both

Client has the ability to point with ☐ hands ☐ finger ☐ eyes

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

Please check the form(s) of mobility 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 brand and model number of wheelchair(s) if applicable:

Brand:	Model:
Brand:	Model:

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HEALTH RECORD:

Describe the client's general health:	
Are they currently under medical treatment or taking medication? ☐ Yes ☐ No If yes, please list below:	
Who is the primary care physician?	
Name:	Phone:
Address:	Fax:

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List and describe any hospitalization, operations, or accidents within the last ten years (indicate age at time of occurrence).

Event	Age

Does the client have any specific medical needs we should know about (e.g., allergies, asthma, seizures) Please list:

Have any other members of the family had speech and/or hearing difficulties? Please describe.

Does anyone in the family have a history of the following:

Area of Concern	Relationship to Client
☐ Speech and Language	
☐ Autism	
☐ Hearing Impairment	
☐ Traumatic Brain Injury/Concussion	
☐ Intellectual Disability	
☐ Cerebral Palsy	
☐ Mental Health	
☐ Chronic Illness:	

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Has the client ever had a neurological or neuropsychological evaluation? ☐ Yes ☐ No If yes, please complete the following section.	
Type of evaluation:	Date of evaluation:
Name of clinic or hospital:	Address:

Does the client have any fears, concerns, or things that create anxiety?
When at home, what is the client most likely to be found doing?
What do you enjoy doing with the client?
What are the client's favorite toys/activities?
What are some of the client's interests? What do they gravitate to or are they passionate about?

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What are the client's favorite videos/shows/books?		
Does the client replay segments of YouTube videos over and over?	☐ Yes	☐ No

Please indicate if the client seeks or avoids the following (if neither, please leave row blank):		
	Seeks	**Avoids**
Visual (e.g., bright colors, contrast colors, lights on/off/dimmed)		
Tactile (e.g., alerted/calmed by touch/avoid or seek textures)		
Gustatory/oral (e.g., seeks out intense flavors, crunchy foods, puts objects in mouth)		
Vestibular (e.g., swinging, spinning, bending upside down is calming/overwhelming)		
Proprioceptive (e.g., crashes into pillows/people, seeks climbing, jumping)		
Auditory (e.g., puts hands over ears, enjoys music/musical toys)		

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May we have your permission to request information about the evaluation and/or therapy mentioned above to assist us in our evaluation of your present difficulty? ☐ Yes ☐ No

If yes, please fill out one of the attached "AUTHORIZATION FOR RELEASE OF INFORMATION" forms. If the evaluation and therapy took place in more than one place, please fill out one form for each setting.

Are there any limitations on your schedule that would make it impossible for you to come for an evaluation on any specific day? ☐ Yes ☐ No If yes, please describe:

If you have any other information which you feel would be helpful to us in preparing for your evaluation, please write it in the space provided here.

Thank you for your time in filling out this form. Please email past assessments to SLHC@northeastern.edu, fax to 617-373-8756, or send via mail to:

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