



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

TODAY'S DATE:

**IDENTIFYING INFORMATION:**

<p><b>Name of person filling out this form:</b></p> <p><b>Pronouns:</b></p> <p><b>Email address:</b></p>
--

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

*Department of Communication Sciences & Disorders*  
**Speech-Language and Hearing Center**  
503 Behrakis Health Science Center Boston, MA 02115  
(617) 373-2492

---

Medical Diagnoses:

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

*Department of Communication Sciences & Disorders*  
**Speech-Language and Hearing Center**  
**503 Behrakis Health Science Center Boston, MA 02115**  
**(617) 373-2492**

---

**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?

*Department of Communication Sciences & Disorders*  
**Speech-Language and Hearing Center**  
**503 Behrakis Health Science Center Boston, MA 02115**  
**(617) 373-2492**

Has the client had a speech and language or Augmentative and Alternative Communication Evaluation at school or any other clinic?	Yes	No
If yes, please list those that occurred in the last <b>five years</b> :		
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?

*Department of Communication Sciences & Disorders*  
**Speech-Language and Hearing Center**  
**503 Behrakis Health Science Center Boston, MA 02115**  
**(617) 373-2492**

---

Is the client served by an Individualized Education Plan (IEP) or 504 Plan?	IEP Neither	504
When did the client first begin to receive services?		
Has the client received prior <b>Speech Therapy</b> 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 <b>ABA Therapy</b> ?	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 <b>Occupational Therapy</b> ?	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?		

*Department of Communication Sciences & Disorders*  
**Speech-Language and Hearing Center**  
**503 Behrakis Health Science Center Boston, MA 02115**  
**(617) 373-2492**

---

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

*Department of Communication Sciences & Disorders*  
**Speech-Language and Hearing Center**  
**503 Behrakis Health Science Center Boston, MA 02115**  
**(617) 373-2492**

---

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:

*Department of Communication Sciences & Disorders*  
**Speech-Language and Hearing Center**  
**503 Behrakis Health Science Center Boston, MA 02115**  
**(617) 373-2492**

**HEALTH RECORD:**

Describe the client's general health:	
Are they currently under medical treatment or taking medication? <span style="float: right;">Yes      No</span>	
If yes, please list below:	
Who is the primary care physician?	
Name:	Phone:
Address:	Fax:



*Department of Communication Sciences & Disorders*  
**Speech-Language and Hearing Center**  
**503 Behrakis Health Science Center Boston, MA 02115**  
**(617) 373-2492**

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:	

*Department of Communication Sciences & Disorders*  
**Speech-Language and Hearing Center**  
**503 Behrakis Health Science Center Boston, MA 02115**  
**(617) 373-2492**

Has the client ever had a neurological or neuropsychological evaluation? If yes, please complete the following section.		Yes	No
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?



# Northeastern University

*Department of Communication Sciences & Disorders*  
**Speech-Language and Hearing Center**  
**503 Behrakis Health Science Center Boston, MA 02115**  
**(617) 373-2492**

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

Please indicate with an x 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)		

*Department of Communication Sciences & Disorders*  
**Speech-Language and Hearing Center**  
**503 Behrakis Health Science Center Boston, MA 02115**  
**(617) 373-2492**

---

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. If the client has an IEP or a 504 Plan, please email this documentation to [SLHC@northeastern.edu](mailto:SLHC@northeastern.edu), fax to 617-373-8756, or send via mail to:

Claudia Lywood  
Northeastern University  
360 Huntington Ave  
503 BK  
Boston, MA 02115