NOVA SOUTHEASTERN UNVIERSITY
Tyler Institute

AUGMENTATIVE COMMUNICATION
Case History: Adult Form

IDENTIFYING INFORMATION

Name of Child: _____ Date of Birth: _____

Name of Person Completing Form: _____ Today's Date: _____

Relationship to Child: _____ Child's Social Security #: _____

Child's Address: _____

Child's Phone Number: _____

Who referred you to the Clinic? _____

List any medical diagnoses the child has: _____

_____

When was he/she first diagnosed with that condition? _____

Why were you referred? _____

_____

With whom does the child live? _____

What do you hope to accomplish by coming to the Clinic? _____

_____

_____

Has the child in the past, or does he/she currently use an augmentative communication device or any assistive technology at home or at work? ❑ Yes ❑ No

If he/she has used in the past only, briefly explain why he/she is not currently using: _____

_____

_____

_____

Who evaluated the child for the augmentative communication device or assistive technology? _____

_____

EDUCATIONAL & VOCATIONAL INFORMATION

Educational level: _____
(If post-high school, indicate area of specialization)

Occupation: _____ Employer: _____

Last Date of Employment: _____

FAMILY INFORMATION

Marital status: single _____ married _____ separated _____ divorced _____ remarried _____

Name of spouse: _____ No. of years married: _____

Address of spouse: _____

Occupation: _____ Educational level: _____

Work Phone: _____

Children:

Names **Ages**

_____

_____

_____

_____

COMMUNICATION STATUS

How would you describe the child's current communication ability (check all that apply)

_____ Almost never communicates
_____ Sometimes communicates
_____ Communicates frequently

_____ Is very easy for me to understand when I know the topic of conversation
_____ Is fairly easy for me to understand when I know the topic of conversation
_____ Is difficult for me to understand when I know the topic of conversation

_____ Is very easy for me to understand if I DON'T know the topic of conversation
_____ Is fairly easy for me to understand if I DON'T know the topic of conversation
_____ Is difficult for me to understand if I DON'T know the topic of conversation

_____ Is usually understood by other people who don't know him/her well
_____ Is usually NOT understood by other people who don't know him/her well

In your own words, please describe how the child communicates:

In general:

He/She communicates what he/she wants or needs by:

He/She communicates things that happened in the past or will happen in the future by:

He/She gives or asks for information by:

He/She communicates in social situations by:

What other things does he/she do to communicate (e.g. cry, whine, look at something he wants)?

What sounds does the child make? (e.g. “b”, “duh”, “ee” as in eat”)

_____

_____

What words does this child say or write?

_____

_____

What gestures does this child make (e.g. pointing, motioning, to “come here”, tugging for attention?)

_____

_____

What manual signs (or sign language) does the child use?

_____

_____

What other services does the child have now? What has he/she had in the past?

	Has Now	Had Before
Physical Therapy		
Occupational Therapy		
Speech-Language Therapy		
Psychological or Behavioral Counseling		
Nutritional Services		
Vocational Counseling		
Other (describe):		

EDUCATIONAL INFORMATION

Child's School: _____

School Address: _____

_____

School Phone: _____

Placement/Grade: _____

Teacher's Name: _____

Does the child have an aide with him/her in school? Yes _____ No _____

If YES, is the aide with the child:

_____ All day

_____ About half of the day

_____ Less than half of the day

Does this aide work with:

_____ Just this child

_____ Several children

_____ The whole class

DEVELOPMENTAL INFORMATION

Check which is applicable: This is our biologic_____ foster_____ adopted_____ child.

How many pregnancies has the mother had? _____ Which was this child? _____

Mother's age at the time of this pregnancy? _____

Any medical problems before this pregnancy? _____ If yes, describe: _____

_____

_____

Did the mother have any of the following during pregnancy?

German measles _____ Toxemia _____ Anemia _____ Kidney infection _____

Accidents, injures (describe) _____

_____

_____

Did the mother take any prescription and or nonprescription medications during this pregnancy?

Yes _____ No _____

What kinds? _____

Was the pregnancy full term? _____ Premature? _____ Number of months? _____

Was the delivery normal? _____ Length of hard labor? _____ Were forceps used? _____

Caesarian/Breech? _____

Comments: _____

Give the name of physician and hospital: _____

_____

Child's weight at birth? _____ Any birth injuries? _____

Was the child an RH baby? _____ Was the child jaundiced? _____

Did the child require oxygen? _____

What special medication or treatment did the child receive at birth, if any? _____

_____

Breast or bottle fed? _____ If breast fed, for how long? _____

Did the infant have feeding problems? _____

If "yes", explain _____

_____

Swallowing or choking difficulty? Yes _____ No _____ If "yes" explain: _____

_____

Sat alone _____months. Fed self_____ months. Walked alone _____ months.

Determined handedness _____ (age).

Toilet trained during the day _____ (age). Toilet trained during the night _____ (age).

Physical development has been: rapid _____ normal _____ slow _____.

Coordination is: good _____ clumsy _____.

Does the child use any of the following? (Check all that apply).

_____ Wheelchair

_____ Walker

_____ Special Chair

_____ Other special equipment (describe) _____

Feeding difficulty: Yes _____ No _____. If "yes",

Explain: _____

_____

Check all those that apply to the child:

	Yes	No	Explain: give ages if possible
Eating problems			
Sleeping problems			
Toilet trained problems			
Difficulty concentrating			
Needs a lot of discipline			
Interactive			
Excitable			
Laughs easily			
Cries a lot			
Difficult to manage			
Overactive			
Sensitive			
Personality problems			
Gets along with adults			
Emotional			
Stays with an activity			
Makes friends easily			
Happy			
Irritable			

Would the child separate easily for therapy? Yes_____ No _____

What are your primary concerns about your child? _____

_____

SPEECH AND LANGUAGE HISTORY

Was the child responsive as an infant? (Smile or laugh appropriately) Yes _____ No _____

If "no", explain:

_____

_____

When did the child first make sounds? _____ months

Examples of early sounds _____

Did the child begin to babble and then stop? Yes _____ No _____

When did the child say his/her first words: _____ months

Examples of early sounds _____

When did the child say his/her first words: _____ months

Examples of first words: _____

When did the child first use phrases: _____

Examples of phrases: _____

When did the child first use sentences: _____ months

Examples: _____

When were you first concerned about the child's speech or language _____

What caused the concern? _____

How does the child communicate at this time? Provide examples of his present communication:

_____

_____

Can child be understood by:

Mother _____ Relatives _____ Other children _____

Father _____ Strangers _____

Is child having difficulties in any area other than speech? Yes _____ No _____

If "yes", explain: _____

_____

What words does this child say or write?

_____

_____

What gestures does this child make (e.g. pointing, motioning to "come here," tugging for attention)? When does he/she use these gestures?

_____

_____

What manual signs (or sign language) does the child use? When does he/she use these signs?

_____

_____

What other things does he/she do to communicate (e.g. for look at something he wants, blink eyes)?

_____

_____

MEDICAL HISTORY

	Age	Mild	Mod.	Severe		Age	Mild	Mod.	Severe
Adenoidectomy					Heart problem				
Allergies					High fevers				
Asthma					Influenza				
Blood disease					Mastoidectomy				
Cataracts					Measles				
Chicken pox					Meningitis				
Convulsions seizures					Muscle disorder				
Cross-eyed					Nerve disorder				
Croup					Orthodentia				
Dental problems					Pneumonia				
Diptheria					Polio				
Encephalitis					Rheumatic fever				
Headaches					Scarlet fever				
Head injuries					Tonsillectomy				
Vision Problems					Whooping cough				

Describe any other illnesses, accidents, injuries, operations, and hospitalization of the child.

Include the age of the child and length of hospitalization: _____

_____

_____

Is the child's health Good? _____ Fair? _____ Poor? _____

Is the child now under medical treatment or on medication? Yes _____ No _____

Please describe any treatment or medication: _____

_____

HEARING HISTORY

Does the child have a history of ear infections or otitis media? _____

How many occurrences or ear problems? _____

At what ages? _____ Age of onset? _____

How long did each ear problem last? _____

What treatments (medications) were prescribed? _____

Has the child ever been treated by an Ear, Nose, and Throat doctor? _____

Who? _____ When? _____

Says "huh?" or "what?" at least five or more times a day? Yes _____ No _____

Do you ever question the child's ability to hear normally? _____

Why? _____

Has the child complained of noises in his ears? _____

Is hearing the same from day to day? _____ When does it change? _____

Does the child become confused with direction of sound? _____

Does the child seem to hear less well in noise? _____

Does the child seem annoyed by a noisy environment or loud sounds? _____

Does the child favor one ear? _____ Which one? Left _____ Right _____

Does the child favor one ear? _____ Which one? Left _____ or Right _____

Does the child watch the speaker's face? _____

Does the child respond to vibration? _____

Has the child ever worn a hearing aid? _____

Is the child easily distracted? _____

Does the child have difficulty following directions? _____

Does the child localize to environmental sounds? _____

Does the child have difficulty following auditory directions? _____

INSURANCE INFORMATION

Insurance If yes, Company Name: _____

Policy Number: _____

Does insurance cover speech-language therapy? _____

Who is responsible for the child? _____

Relationship? _____

Child's Doctor: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____