Star Center
disabilities for life.

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Augmentative Communication
Pre-Evaluation Intake

Please include the following documents, as applicable:

☐ Recent medical or developmental testing results
☐ Recent hearing and vision testing results
☐ Recent IEP or ISP
☐ Recent speech therapy reports
☐ Recent occupational therapy reports
☐ Recent physical therapy reports

Name of person completing this form: _____ Date: _____

Relationship to client: _____ How long have you known this individual? _____

Identifying Information:

Client's full name: _____ Date of birth: _____

Gender: _____ Social security number: _____Home phone: (____) _____

Street address: _____ Other phone: (____) _____

City: _____ County: _____ State: _____ Zip: _____

Who else lives in the home? (e.g., mom, dad, siblings, roommate, personal assistant) _____

_____

Caregivers' Name(s), Address, and Phone (if different from above): _____

_____

Relationship to Client (e.g., spouse, parent, grandparent, etc): _____

Support Personnel: ISC? _____ Case Manager? _____

VR Counselor? _____ Other? _____

Other primary contacts, phone numbers (cell, work), addresses: _____

_____

_____

What are you hoping to gain from this evaluation? _____

_____

Medical Information:

Diagnosis: _____ Date of onset: _____ ICD9 Code (if known): _____

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Has the client been hospitalized for any significant illness or disease? ☐ *Yes* ☐ *No*

If yes, what and when? _____

Has the client had any surgical procedures? ☐ *Yes* ☐ *No*

If yes, what and when? _____

History of seizures? ☐ *Yes* ☐ *No* Currently? ☐ *Yes* ☐ *No* If yes, how often? _____

Current Medications and Reason for Taking: _____

_____

_____

Physician**:** _____ Phone: _____

Clinic: _____ Fax: _____

Street address: _____

City: _____ County: _____ State: _____ Zip: _____

NPI: _____ License #: _____ UPIN: _____ Medicaid #:_____

Hearing and Vision:

Do you think the client has problems hearing? ☐ *Yes* ☐ *No* Hearing aids? ☐ *Yes* ☐ *No*

If yes, explain: _____

Date and location of last hearing exam: _____

Do you think the client has problems seeing? ☐ *Yes* ☐ *No* Glasses/contacts? ☐ *Yes* ☐ *No*

If yes, explain: _____

Date and location of last vision exam: _____

Fine and Gross Motor Development:

Does the client have problems with movement? ☐ *Yes* ☐ *No* If yes, explain: _____

_____

Skill	*Independent*	*Requires Assistance*	*Unable*
Holds head steady			
Sits			
Walks			
Feeds self			
Isolates finger and points			

Handedness? ☐*right* ☐*left* Client can use: ☐*both hands*? ☐*one hand (R / L)*? ☐*neither hand*?

List any special equipment the client uses (walker, stander, wheelchair, splints, etc.): _____

_____

Speech and Language:

Does client <u>initiate</u> communication/interaction? ☐ *Yes* ☐ *No*
Does client <u>respond</u> to communication/interaction? ☐ *Yes* ☐ *No*

What, if any, percentage of client's speech is understood by: Familiar people: _____ %

Unfamiliar people: _____ %

Forms of communication used by client (Mark <u>all</u> that apply):

<u>Mode</u>	**<u>X</u>**	**<u>Examples</u>**
Gestures		
Sign Language		
Facial Expressions		
Picture Symbols		
Voice Output Device		
Yes/No Responses		
Vocalizations (sounds)		
Verbalizations (words)		

Has <u>any</u> type of augmentative communication been used and/or recommended in the past? ☐ *Yes* ☐ *No*

If yes, what? _____

Identifies <u>real objects</u>: ☐ *Yes* ☐ *No* Examples: _____

Identifies <u>pictures/symbols</u>: ☐ *Yes* ☐ *No* Examples: _____

Knows how objects are used: ☐ *Yes* ☐ *No* Examples: _____

Can group similar items together (e.g., clothes, food)**:** ☐ *Yes* ☐ *No* Examples: _____
Follows directions: ☐ *one-step* ☐ *two-step* ☐ *three-step*

Examples: _____

How does the client request objects or activities? _____

How does the client reject/protest objects or activities? _____

Does the client understand much more than he/she is able to communicate? ☐ *Yes* ☐ *No*

Identifies Numbers: ☐ *Yes* ☐ *No* Letters**:** ☐ *Yes* ☐ *No* Shapes: ☐ *Yes* ☐ *No* Colors: ☐ *Yes* ☐ *No*

Sight Words: ☐ *Yes* ☐ *No* Reads a Variety of Words: ☐ *Yes* ☐ *No* Reads Phrases: ☐ *Yes* ☐ *No*

Reads Sentences: ☐ *Yes* ☐ *No* Reads for Pleasure: ☐ *Yes* ☐ *No* Approximate reading level: _____grade

Therapy services:

Service	*Start date*	*Frequency*	*Provider*	*Goals*
PT				
OT				
Speech				
(Other)				

Education/Employment:

Is the client enrolled in school? ☐ *Yes* ☐ *No* Highest grade completed: _____

Classroom setting(s) and hours per day: _____*Inclusion/Regular* _____*Resource* _____*Self-Contained*

Educational Assistant? ☐ *Yes* ☐ *No* *One-on-one* or *shared*? (please circle one)

Name of school(s) and dates of enrollment: _____

_____

Is the client employed? ☐ *No* ☐ *Currently* ☐ *Previously* If applicable, provide places of employment, dates and job title: _____

Personal (How the communication impairment affects the client's life):

How would you describe the client's behavior? _____

_____

What is motivating to the client? List examples of the client's favorite things, where applicable:

Music/Songs	
Drinks/Foods	
TV Shows/Movies	
People	
Places	
Activities/Hobbies	
Games/Toys	
Other	

In these areas, what kinds of things does the client wants to say, but can't?

Personal _____

Social _____

Work/School _____

Safety/Health _____

In what different settings does the client need to communicate throughout the day? _____

_____

Who does the client need to communicate with? _____

_____

Any additional information that you feel would be helpful: _____

_____

_____

_____

Upon completion, please return all documentation to **AAC Consultant**.