AUGMENTATIVE AND ALTERNATIVE COMMUNICATION SERVICES
DEPARTMENT OF COMMUNICATION DISORDERS
HEALTH PROFESSIONS BUILDING 2169
CENTRAL MICHIGAN UNIVERSITY
MT. PLEASANT, MI 48859

AUGMENTATIVE COMMUNICATION PRE-ASSESSMENT FORM

Complete this form and return via snail mail to:
Theresa Jones, Director of Clinical Instruction
Department of Communication Disorders, HPB 2187
Central Michigan University, Mount Pleasant MI 48859
Phone = (989) 774-3960, fax = (989) 774-1891
https://www.cmich.edu/colleges/CHP/hp_academics/communications_disorders/clinical_programs/Pages/AACCenter.aspx

Today's date:_____________

DEMOGRAPHIC INFORMATION

Name______________________Birthdate____________Age__________Sex________
Address ____________________Phone_____________ Email Address______________
City ________________________State_______ Zip Code__________________

*Person completing questionnaire ____________________________________________

*Relationship to client______________________________________________________

*Address/Phone/email of person completing questionnaire __________________________

INSURANCE INFORMATION -- We may need a referral from your physician in order to bill your insurance for this evaluation. Please provide the following information so we can evaluate whether this is the case with your insurance.

Primary Insurance:

Insurance Name__________________________________________________________

Cardholder’s Name________________ Cardholder’s Date of Birth________________

Cardholder is: (circle) Child Parent Self Spouse

ID# from Insurance Card ____________________Group # _______________________

Secondary Insurance:

Insurance Name__________________________________________________________

Cardholder’s Name________________ Cardholder’s Date of Birth________________

11/14/2018 AAC Pre-Assessment Form
Revised November 19, 2019
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CURRENT COMMUNICATION IMPAIRMENT

STATEMENT OF THE PROBLEM
Please describe the communication problem for which you are seeking AAC services:

MEDICAL INFORMATION
What is the medical diagnosis of the client? (For example cerebral palsy, seizure disorder, ALS etc.)

Describe any recent medical or dental procedures the client has had or has planned in the near future.

What medications is the client presently taking and for what reasons?

COMMUNICATION
Date of most recent speech/language evaluation:

Receptive information:

Does the client seem to have difficulty understanding speech?
Yes? _____ No? ________

Please describe:

Please indicate the client's current level of understanding by checking the following:
Does not understand spoken words ______________________

Understands single words ____________________________

Understands simple sentences_________________________

Understands 2 and 3 part commands _______________

Understands conversations ____________________________

**Expressive information:**

Does client attempt to communicate?

Does the client initiate communication? Yes____ No____

If yes, with whom does the client attempt to communicate?

Please indicate all means of communication currently used: (If possible, rank order from most to least frequently used; 1 being most frequent.)

Speech ___________________________ Eye pointing ___________________________

Vocalization ________________ Spoken yes/no ________________

Manual signing* ________________ Gestural yes/no ________________

Facial expressions _______________ Bodily gestures _______________

Communication equip. ____________ Writing ______________________

*What type of signs (e.g. ASL etc.) does the client use and about how many does he/she use spontaneously?

What is the approximate rate of client’s current communication? E.g. words per minute)

**SPOKEN COMMUNICATION**

If the client speaks, please indicate if speech is:

Understood by strangers ___________________________

Understood by family/close associates only ___________________________

Difficult for family/close associates to understand ___________________________

Is never understood by others ___________________________
Indicate average number of words in client’s message
_____________________________________

What percentage of the client’s speech are you able to understand? (Please circle.) 100% 
75% 50%

If client is not understood, is he/she:
Quickly discouraged__________ Persistent __________
Frustrated ________________ Apathetic _________
Has the client ever spoken better than he/she does now?

**AIDED COMMUNICATION** (Use of communication boards, electronic devices etc.)

Please describe the type of aided communication system/device currently used:

How long has the client been using the device described? ________________

Please list all communication systems used in the past and check whether the system proved to be unsuccessful or unsuccessful.

<table>
<thead>
<tr>
<th>System</th>
<th>Successful</th>
<th>Unsuccessful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(State possible reason for lack of success.)</td>
</tr>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

How are (or would) vocabulary items represented on the client’s communication board/device? Also what size and how many items?

Photographs __________ Size ___________ Number ______________

Color pictures __________ Size ___________ Number ______________

Line drawings __________ Size ___________ Number ______________

Letters/words __________ Size ___________ Number ______________

Other _________________ Size ___________ Number ______________

If possible, list the vocabulary items displayed on the client’s communication aid.

The client primarily uses the communication aids/devices:
Imitatively ________________________
In response to questions ________________________
In response to commands ______________ (Example: "Show me what you want.")

Spontaneously ________________ (i.e. on his/her own initiative without cueing)

Are modifications necessary to accommodate visual impairments? (i.e. color contrast, placement of pictures on overlays, etc.)

Does the client combine symbols to form a message? How many?

Identify switch, activation site, and reliability of site (if applicable):

List any other adaptive equipment necessary for use with the communication system:

**EDUCATION/LITERACY** (Check here if this section not applicable________)

Does the client currently attend a school program?_____________________

If yes, what is current classroom placement? Include Special Education Certification if applicable (e.g. SXI, EMI etc.)

<table>
<thead>
<tr>
<th>Literacy Skills</th>
<th>N/A</th>
<th>Emergent</th>
<th>Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizes rhyme</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifies number of letters in a word</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifies letters of the alphabet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understands letter sound correspondence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decodes unknown words</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spells words</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reads independently</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses strategies to support comprehension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answers comprehension questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composes text with assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Writes independently</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Estimated literacy level for both reading and writing (emergent, pre-primer, primer, grade 1, etc.)?_______________________________________________

What literacy activities does this client engage in on a regular basis (emergent literacy activities, decoding, guided reading, independent reading, writing)? How often?
COGNITIVE INFORMATION

Does client demonstrate functional object use; that is, play with or use objects in the way that they are typically used (e.g. puts phone to ear, spoon to mouth etc.)?

If not, please describe the client’s interaction with objects by checking those actions he/she typically engages in:
- Puts objects in his/her mouth
- Hits/bangs objects on a surface
- Shakes objects
- Drops or throws objects on the floor
- Other (please specify) _______________________________________________________

Has the client has a psychological/psycho-educational evaluation prior to this time?
- Yes_______ No _____
- Date and results of most recent testing:_________________________________

VISION

Does the client have any visual problems? Yes?_____ No? _____
- Does client wear glasses? Yes?_____ No? _____
- In what situations?
- Date of most recent vision testing____________________________
- Test results:

HEARING

Does the client seem to have any difficulty hearing? Yes?_____ No? _____
- If so, please describe:
- Date of most recent hearing test _________________________________
- Test results:

MOTOR ABILITIES (Check here if this section not applicable___________)

If applicable, please check all that apply:

<table>
<thead>
<tr>
<th>Movement</th>
<th>Normal</th>
<th>Able but slow/labored</th>
<th>Too weak or uncoordinated without assistance</th>
<th>Unable without assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holds head steady</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Sits without help
Walks
Uses hands

Does client fall or lose balance easily?

In what position does client spend the majority of the time at home? (Please check one):

<table>
<thead>
<tr>
<th>Sitting</th>
<th>Semi-reclined</th>
<th>On back</th>
<th>On stomach</th>
<th>On side (Right)</th>
<th>(Left)</th>
</tr>
</thead>
</table>

Apparatus/aids: Please check boxes in this table that apply

<table>
<thead>
<tr>
<th>Uses presently</th>
<th>Used in the past</th>
<th>Never used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheelchair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower extremity braces</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back brace/trunk support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crutches/cane/walker</td>
<td></td>
<td></td>
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<tr>
<td>Splint(s) where?</td>
<td></td>
<td></td>
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<tr>
<td>Overhead sling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headstick</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Computer</td>
<td></td>
<td></td>
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<tr>
<td>Dressing aids</td>
<td></td>
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<tr>
<td>Transfer aids</td>
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<tr>
<td>Feeding aids</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

If wheelchair is used, please describe the following:

Make _____________________________________________________________
Motorized ___________________ Manual _________________________
Insert components _______________ Lap belt ______________________
Harness ________________________ Lap tray measurements __________
Independent mobility _____________________________
Activities tray is used for _____________________________________

Does client prefer the right or left hand? ________________________________

Most reliable movement patterns:
Pointing ___________________________ Eye pointing _______________________
Raising arm ______________________ Other e.g. foot or knee etc. ___________
Does client have difficulty chewing or swallowing?  Does he/she drool?

**SOCIAL INFORMATION/ COMMUNICATION NEEDS**

Describe the client’s interactions with others:

Please list the items the client most frequently desires/ attempts to indicate:

**Food:**

Activities/toys:

Daily needs:

Other:

Is the client currently employed? Yes? _______ No? _______

If so, please describe duties and communication needs in the work place.

**THERAPEUTIC HISTORY**

List all therapeutic/services the client is currently receiving in the table below:

<table>
<thead>
<tr>
<th>Type of Service (ST, OT, PT etc.)</th>
<th>Frequency (# month)</th>
<th>Duration ( # minutes per ‘session’)</th>
<th>Site (School, outpatient etc.)</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

If an AAC system is recommended, who will be the people to implement the AAC system for/with the client?

**SUPPORT SERVICES**

Indicate agencies for possible financial assistance:
Children’s Special Health Care Services ____
Medicaid __________ Vocational Rehabilitation ___________________________ Medicare
________________ Private Insurance (company) __________________________
SSI __________________ Church group _________________________________
Service Group ______ Fund raisers ______________________________________
Other (explain) __________________

**ADDITIONAL INFORMATION**

What do you feel are the client’s major assets?

What do you feel are the client’s major problems or concerns for the future?

What do you expect from this evaluation?