



# AAC Adult Case History Form

Name \_\_\_\_\_ Date \_\_\_\_\_

Date-of-Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Home Work Cell (CIRCLE ONE)

Home Work Cell (CIRCLE ONE)

Email Address \_\_\_\_\_

Occupation/Former Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Highest Level of Education Completed \_\_\_\_\_

Name of Spouse or Nearest Relative \_\_\_\_\_

Native Language \_\_\_\_\_ Primary Language \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Referred by \_\_\_\_\_

Person Completing this Form \_\_\_\_\_ Relationship \_\_\_\_\_

## MEDICAL HISTORY

1. What is your primary disability?

\_\_\_\_\_  
\_\_\_\_\_

2. Is your disability the result of a recent accident or illness? If so, please explain.

\_\_\_\_\_  
\_\_\_\_\_

3. Do you have any medical conditions which have affected your ability to communicate? If yes, please indicate the type of condition.

\_\_\_\_\_  
\_\_\_\_\_

4. Are you presently taking any medication? If so, please list and indicate reason for taking them.

\_\_\_\_\_  
\_\_\_\_\_

5. Describe any pertinent surgery you have had. Indicate year of the surgery.

\_\_\_\_\_  
\_\_\_\_\_

6. Have you ever had any of the following? Please check all that apply:

Influenza

Stroke

Seizures

Pneumonia

Meningitis

Encephalitis

Heart Disease

Weakness of arms or legs

Uncontrollable trembling

Difficulty swallowing

Shortness of breath

Measles

Allergies

Sinus problems

Frequent colds

Thyroid problems

Other (please describe) \_\_\_\_\_

### VISION STATUS

1. Please check appropriate box:

No visual impairment

Visual impairment

2. Date of most recent vision exam \_\_\_\_\_

3. Results \_\_\_\_\_

4. Do you wear glasses or contacts? If so, for what purposes? \_\_\_\_\_

### HEARING STATUS

1. Please check appropriate box:

No hearing loss

Hearing loss

2. Date of most recent hearing exam \_\_\_\_\_

3. Results \_\_\_\_\_

4. Do you wear a hearing aid?

Yes

No

5. Do you use a sign language?

Yes

No

### MOTOR STATUS

1. Please check appropriate box:

No motor loss

Motor impairment (if yes, please answer below)

2. Are you ambulatory? \_\_\_\_\_

3. Do you require any special equipment for mobility purposes? \_\_\_\_\_
4. Please describe the nature of your physical impairment. \_\_\_\_\_
5. Please describe paralysis or paresis, if any exists. \_\_\_\_\_

### COMMUNICATION STATUS

1. Why do you wish to be evaluated at our clinic? \_\_\_\_\_
2. How do you communicate most of the time? (Check any appropriate boxes)
- |   |   |
|---|---|
| <input type="checkbox"/> Speech   | <input type="checkbox"/> Manual signs (ex. pointing, gesturing, etc.) |
| <input type="checkbox"/> Photographs/pictures                                   | <input type="checkbox"/> Communication board                          |
| <input type="checkbox"/> Electronic communication device (please specify) _____ | <input type="checkbox"/> Sign Language                                |
| <input type="checkbox"/> Other _____  |   |
3. If you have communicated by means other than speech in the past (ex. gesturing, devices, etc...), please describe your successes or failures using them.
- \_\_\_\_\_
- \_\_\_\_\_

4. Check the appropriate column as it applies to you now:

CAN	CAN'T	
<input type="checkbox"/>	<input type="checkbox"/>	Indicate meaning by gesture
<input type="checkbox"/>	<input type="checkbox"/>	Repeat words spoken by others
<input type="checkbox"/>	<input type="checkbox"/>	Use one or a few words over & over
<input type="checkbox"/>	<input type="checkbox"/>	Use swear words often
<input type="checkbox"/>	<input type="checkbox"/>	Use some words spontaneously
<input type="checkbox"/>	<input type="checkbox"/>	Say short phrases
<input type="checkbox"/>	<input type="checkbox"/>	Say short sentences
<input type="checkbox"/>	<input type="checkbox"/>	Follow requests
<input type="checkbox"/>	<input type="checkbox"/>	Understand directions
<input type="checkbox"/>	<input type="checkbox"/>	Follow radio or TV speech
<input type="checkbox"/>	<input type="checkbox"/>	Read signs with understanding
<input type="checkbox"/>	<input type="checkbox"/>	Read newspapers, magazines
<input type="checkbox"/>	<input type="checkbox"/>	Tell time
<input type="checkbox"/>	<input type="checkbox"/>	Write name without assistance
<input type="checkbox"/>	<input type="checkbox"/>	Write sentences, letters
<input type="checkbox"/>	<input type="checkbox"/>	Do simple arithmetic
<input type="checkbox"/>	<input type="checkbox"/>	Handle money and make change

**PERSONAL INFORMATION**

1. Please describe your involvement in activities (i.e., church, sports, hobbies...).

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2. Please describe your typical daily activities and in what settings (home, work, etc.) they occur.

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3. Have your communication difficulties since the injury changed your life? If so, how?

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4. Are there times of day or situations in which your communication is better? Worse? Please explain.

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5. How do others react to your communication?

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6. Please list those family and friends with whom you regularly interact with.

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7. Would you be willing to use a communication board or device if recommended? Why or why not?

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8. Will significant others be participating in this evaluation? If so, who?

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9. Are significant others willing to learn and use a non-speech communication system?

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10. If recommended for a device, how would you fund the device?

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11. Are there any concerns you would like to discuss regarding your communication?

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