


ECKELMANN-TAYLOR SPEECH AND HEARING CLINIC
Illinois State University

AAC Child Case History Form

Name _____ Date _____

Date-of-Birth _____ Age _____

School _____ Grade _____

Native Language _____ Primary Language _____

_____ _____

Mother's Name _____ Address _____

Phone _____ Alernate Phone _____

Home Work Cell (CIRCLE ONE) Home Work Cell (CIRCLE ONE)

Email Address _____

_____ _____

Father's Name _____ Address (if different) _____

Phone _____ Alernate Phone _____

Home Work Cell (CIRCLE ONE) Home Work Cell (CIRCLE ONE)

Email Address _____

_____ _____

Person Completing Form _____

Physician's Name _____ Phone _____

Referred by _____

DISABILITY INFORMATION

1. What is the child's primary disability?

_____

_____

2. Are there any secondary disabilities?

_____

_____

PRENATAL AND BIRTH HISTORY

1. What was mother's general health during pregnancy (illness, accidents, medications, etc.)?

_____

_____

2. Was the child born prematurely? If so, how many weeks early?

_____

_____

3. Were there any complications with labor?

4. What was the child's birth weight?

5. Was the child blue or jaundiced?

6. What number was this child in order of pregnancies?

7. When did he/she sit up unassisted? Walk? Feed himself/herself?

MEDICAL HISTORY

1. Please check your child's diagnosis, if applicable:
   - ☐ Cerebral Palsy
   - ☐ Down's Syndrome
   - ☐ Unknown
   - ☐ Feeding/swallow difficulties
   - ☐ Traumatic Brain Injury
   - ☐ Neurological Disease please specify _____

2. Please indicate if, and at what age(s), the child experienced the following illnesses and conditions:
   - ☐ Allergies _____
   - ☐ Chicken Pox _____
   - ☐ Ear Infection _____
   - ☐ Measles _____
   - ☐ Influenza _____
   - ☐ Mumps _____
   - ☐ Seizures _____
   - ☐ Asthma _____
   - ☐ Croup _____
   - ☐ Encephalitis _____
   - ☐ High Fever _____
   - ☐ Meningitis _____
   - ☐ Pneumonia _____
   - ☐ Tonsillitis _____
   - ☐ Other _____

3. Has the child had any surgeries? If yes, what type and when?

4. Describe any major accidents or hospitalizations.

5. Is the child taking any medications? If yes, please list the names.

CURRENT STATUS

Communication Status

1. Briefly describe the child's intelligibility (how well he/she is understood).

   To you _____

   To members of your family _____

   To others _____

2. What are your present concerns about the child's communication?

_____

_____

3. How does the child react to his/her communication difficulties?

_____

_____

4. How would you like to communicate with the child in the future?

_____

_____

5. Has the child used any assistive devices? If yes, please describe.

_____

_____

6. Is the child currently using a device? If yes, please describe.

_____

_____

7. Please indicate behaviors the child exhibits:

- ☐ Facial expressions
- ☐ Eye gaze
- ☐ Vocalization (i.e lauging, crying)
- ☐ Nonconventional behavior
- ☐ Gestures (i.e. pointing)
- ☐ Meaningful vocalizations
- ☐ Uses manual signs
- ☐ Uses sign language
- ☐ Uses single words
- ☐ 1-10 words
- ☐ 11-20 words
- ☐ 21-30 words
- ☐ More than 30 words
- ☐ Uses phrases/sentences

- ☐ Can read (at what grade level?) _____
- ☐ Can write (at what grade level?) _____

9. Please indicate whether the child demonstrates these behaviors:

- ☐ Attends to speaker or listener
- ☐ Initiates a greeting
- ☐ Takes turns during conversation
- ☐ Introduces new topics
- ☐ Responds to questions
- ☐ Requests help if message is not understood
- ☐ Responds to jokes
- ☐ Tells jokes
- ☐ Understands teasing
- ☐ Understands hints
- ☐ Tries to makes self understood even if message is not understood the first time (if yes, please describe e.g., repeating, pointing, etc….) _____

Vision

1. Please check appropriate box:
   - ☐ Child has no visual impairment
   - ☐ Child has visual impairment (if so, please describe) _____

Hearing

1. Please check appropriate box:
   - ☐ Child has no hearing loss
   - ☐ Child has mild hearing loss
   - ☐ Child has moderate hearing loss
   - ☐ Child has severe hearing loss
   - ☐ Child is deaf

Motor

1. Please check appropriate box:
   - ☐ Child has no motor impairment
   - ☐ Child has motor impairment (If yes, please describe impairment.) _____
2. Is the child ambulatory? If he/she requires adaptive equipment, please specify any special equipment used for mobility process.

_____

_____

Other Sensory Information

1. Is the child over- or under-sensitive to touch?

_____

_____

2. Is the child sensitive to specific textures or tastes? If yes, please explain.

_____

_____

3. Does the child get over stimulated by noise? Visual stimuli? Olfactory stimuli?

_____

_____

Cognition

1. Please check the child's level of:
   Alertness ☐ Very alert ☐ Somewhat alert ☐ Not very alert ☐ Rarely alert
   Attention span ☐ Long ☐ Average ☐ Short
2. Is the child able to express preferences and choices? ☐ Yes ☐ No
   If yes, how does he/she express this? (i.e. gesturing, crying) _____

_____

PERSONAL/FAMILY INFORMATION

1. What are the child's hobbies, interests, favorite playthings?

2. Please list the people which the child regularly interacts with.

3. Is the child cared for outside of home/school? By whom? How long?

4. What is a typical daily schedule of activities for this child?

SUMMARY OF EVALUATIONS

Please indicate any evaluations the child has received and attach any reports indicating the results for:

1. Hearing
   - Date of most recent formal hearing test _____
   - Results _____
   - Audiologist name _____
   - Address _____
2. Motor
   - Date of most recent formal motor test _____
   - Physical therapist _____
   - Address _____
3. Vision
   - Date of most recent formal vision test _____
   - Results _____
   - Optometrist/Ophthalmologist _____
   - Address _____
4. Cognition
   - Date of most recent psychological test _____
   - Results _____
   - Psychologist _____
   - Address _____
5. Communication
   - Date of most recent speech/language test _____
   - Results _____
   - Speech-Language Pathologist _____
   - Address _____