


ECKELMANN-TAYLOR SPEECH AND HEARING CLINIC
Illinois State University

AAC Adult Case History Form

Name _____ Date _____

Date of Birth _____ Age _____ Pronouns _____

Address _____

_____

Phone _____ Alternate Phone _____

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

Email Address _____

Insurance:

Primary _____ Secondary _____

Policy # _____ Policy # _____

Group # _____ Group # _____

Subscriber Name _____ Subscriber Name _____

Subscriber Phone Number & Address _____

Subscriber DOB _____ Subscriber DOB _____

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 the reason for taking them.

_____

_____

5. Describe any pertinent surgery you have had. Indicate the 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 the 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 the appropriate box:
   ☐ No motor impairment ☐ 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)

   ☐ Speech ☐ Manual signs (e.g. pointing, gesturing, etc.)

   ☐ Photographs/Pictures ☐ Communication board

   ☐ Electronic communication device (please specify) _____ ☐ Sign Language

   ☐ Other _____

3. If you have communicated by means other than speech in the past (e.g. 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	
☐	☐	Indicate meaning by gesture
☐	☐	Repeat words spoken by others
☐	☐	Use one or a few words over & over
☐	☐	Use swear words often
☐	☐	Use some words spontaneously
☐	☐	Say short phrases
☐	☐	Say short sentences
☐	☐	Follow requests
☐	☐	Understand directions
☐	☐	Follow radio or TV speech
☐	☐	Read signs with understanding
☐	☐	Read newspapers, magazines
☐	☐	Tell time
☐	☐	Write name without assistance
☐	☐	Write sentences, letters
☐	☐	Do simple arithmetic
☐	☐	Handle money and make change

PERSONAL INFORMATION

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

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

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

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

5. How do others react to your communication?

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

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

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

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

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

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