ASSISTIVE TECHNOLOGY EVALUATION
BACKGROUND INFORMATION QUESTIONNAIRE
AUGMENTATIVE COMMUNICATION FOCUS

GENERAL INFORMATION

Client's Name: ______________________________ Today's Date: ______________________________

Birthdate: __________________ ☐ Male ☐ Female Language(s) Spoken: ______________________________

Weight: _____________ Height: ______________ CFC/Public Aid ID#: ______________________________

Address: ___________________________________ Telephone: ______________________________

___________________________________ E-mail: ______________________________

Type of residence: ☐Family Home ☐Group Home ☐Institution ☐Hospital

Is a change of residence anticipated in the near future? ☐Yes ☐No
If YES, please specify: ____

____

Mother's Name: ______________________________ Father's Name: ______________________________

Address: ___________________________________ Address: ______________________________

___________________________________ ______________________________

Telephone: ___________________________________ Telephone: ______________________________

Names/Ages of Brothers: ____

Names/Ages of Sisters: ____

Have you ever been evaluated before in the Assistive Technology Department? ☐Yes ☐No If yes, approximately when and are you still using the recommended equipment?______________________________

____

Are you a current client of Easter Seals DuPage? ☐Yes ☐No If yes, what services do you receive and who are your therapists?____

Referral made by: ____

Reason for Referral:
- ☐ Unable to communicate wants/needs
- ☐ Somewhat frustrated when unable to communicate clearly
- ☐ Inappropriate behavior associated with communication impairment
- ☐ Emotional issues resulting from communication impairment
- ☐ Health issues resulting from communication impairment
- ☐ Unable to determine specific skills and knowledge without universal, efficient and appropriate communication.
- ☐ Other: ____

____

Name of person completing questionnaire: ____

Relationship to client: ______________________________ Telephone: ______________________________

MEDICAL/BIRTH HISTORY (PLEASE FEEL FREE TO USE THE BACK OF THE PAGE IF MORE ROOM IS NEEDED)

Pregnancy Proceeded: ☐ Normal ☐ with Complications ☐ Adopted, Not known
Explain: ____

____

Birth Hospital: ____
Was baby transferred to another hospital: ☐ Yes ☐ No Hospital: ________________
Length of Pregnancy: _______ Weeks Delivery: ☐ Vaginal ☐C-Section ☐ Emergency C-Section
Delivery proceeded: ☐ Normal ☐ with Complications Explain: ____________________

____

Diagnosis: ____

Onset of condition: ____

Primary Care Physician: ______________________ Telephone: ____________________

Medications: ____

Anticipated course of condition: ☐Stable ☐Improving ☐Deteriorating ☐Fluctuating

Current Medications: ____

____

____

Diagnostic Testing and dates: ____

____

____

____

Current Medical/Health Issues: ____

____

____

Additional medical information: ____

____

____

____

List any joint dislocations, deformities, other orthopedic problems, and past surgeries: ______________

____

Vision: ☐Normal ☐Nearsighted ☐Farsighted ☐Nystagmus ☐Poor tracking ☐Poor scanning
☐Other: ____

Date of Last Vision Assessment: ____

Hearing: ☐Normal ☐Hearing loss in left ear ☐Hearing loss in right ear ☐Wears hearing aides
☐Other: ____

Date of Last Hearing Assessment: ____

Tactile Issues: ☐None ☐Does not like: ______________________________________
☐Other: ____

FUNDING

Agency responsible for funding the evaluation: ______________________________

Address: ______________________________

Contact person(s): ______________________ Telephone: ______________________

POSITIONING/MOBILITY

Mobility: ☐Normal ☐Uses a walker ☐Uses a power wheelchair ☐Uses a manual wheelchair
☐Requires physical assistance ☐Other: ______________________________

Please attach a recent photo of the client in his/her usual position(s) or seating system(s).

Does the client require specialized or customized positioning devices (e.g., insert, special cushion, headrest, etc.)? ☐YES ☐NO. If YES, please specify: ______________________________

How does the client tolerate positioning? ______________________________

Please indicate how many hours per day the client spends in each of the following positions:

Regular chair	
Manual wheelchair	
Powered wheelchair	
Standing unsupported	
Standing in a standing frame	
Lying in bed	
Sitting on the floor or a mat	
Lying on the floor or a mat	

Describe the client's typical transfer, if applicable: ______________________________

Motor Skills

Indicate all that apply:

Activity	Left Hand	Right Hand
Shows hand preference		
Grasps objects		
Releases objects		
Points with a finger		
Types		
Writes with a pen or pencil		

Describe other movements that the client can control (e.g., turn head, lift arm, etc.): ______________________________

Which movement is best? Why? ______________________________

Does the client exhibit any involuntary movements that hinder control? ☐YES ☐NO. If so, specify: ______________________________

LEARNING AND BEHAVIOR

Does the client:

☐Understands that his/her actions can cause something else to happen (push a switch and a light goes on, etc.),

☐Maintains appropriate attention to a task for _______ minutes.

☐Demonstrates ability to make choices between ☐ 2 items ☐pictures ☐activities.

☐ Classifies or groups objects or items (clothing, toys, animals, etc.).

Follows ☐1 step, ☐ 2 step, ☐ multi-step directions in familiar routines/play.

☐Follows age-appropriate conversation

☐ Makes eye contact with people.

☐Benefit from picture schedules or instructions (if checked, can you please attach a sample format or describe)

____

☐ Has behavior management needs or plan (if checked, please explain):_________________________________

____

☐Responds to any behavior modification strategies (if checked, please detail)____________________________

____

☐Other: ____

CLIENT INDEPENDENCE IN SELF CARE SKILLS

For each activity of daily living listed indicate the client's level of functioning, assistive devices used to accomplish the task, the number of years device has been used, and any additional comments you may have.

Activity	Level * (I, A, or D)	Device	Number of Years	Comments
Feeding				
Dressing				
Toileting				
Walking				
Wheelchair Mobility				
Other:				

Level Key: I = Independent, A = Assistance required, D = Dependent

COMMUNICATION SKILLS

How does the client communicate?
Speech Production:

☐Normal

☐Produces speech that consists of ☐ vocalizations (just sounds) ☐ individual sounds (consonants and/or vowels in isolation) ☐ syllables (ex.: ba, ma, da, etc.) ☐ single words ☐ phrases ☐ sentences

☐ Speech has articulation errors

☐ Speech has language errors (ex.: leaves out words, uses wrong tenses, pronouns, etc.)

Speech Intelligibility:

How well do others understand the client's speech?

Family understands speech ☐ easily ☐ with difficulty ☐ not at all.

Teachers understand speech ☐ easily ☐ with difficulty ☐ not at all.

Peers understand speech ☐ easily ☐ with difficulty ☐ not at all.

Strangers understand speech ☐ easily ☐ with difficulty ☐ not at all.

Communication:

☐ Eye Gaze (within limited range and field)

☐ Selects objects ☐ Reaching ☐ Takes another's hand to desired item

☐ Gestures/Facial Expression

☐ Sign Language ---If checked, how many words used ______ and please indicate the type of messages the client is capable of producing:
☐Single words ☐2-word utterances ☐3-word utterances ☐Complete utterances

☐ Photographs (how many? ______) ☐ Line drawings or Picture symbols (how many? ______)

☐ PECS (Picture Exchange Communication System)

☐ Spelling out messages ☐ Handwriting ☐ Typing

☐ Speech-Generating Device: if checked, what device: ____

Indicate all that the client is capable of producing on their system:
☐Single words ☐phrases ☐sentences ☐ questions ☐spells

☐ Yes/No indicated via: ____
☐ Other: ____

Does the client use one method of communication at home and a different method elsewhere? ☐YES ☐NO. If YES, please specify: ____

____

Indicate the client's level of desire to communicate at home and in other environments:

Environment	**Never attempts to communicate**	**Never initiates communication, only responds**	**Occasionally attempts to communicate with others**	**Frequently attempts to communicate with others**	**Initiates conversations**
Home					
School					
Other:					

How frustrated does the client get when you cannot understand him/her? ☐Mild ☐Moderate ☐Severe

What does the client do when you cannot understand him/her?

Does he/she continue to try to communicate or stop communicating? ☐Continue ☐Stop. He/She does this by: ____

____

Does the client get angry when he/she is unable to communicate? ☐YES ☐NO. If YES, please specify: ___

____

How does the client indicate pain or discomfort? ______________________________

____

How does the client indicate new information (e.g., share stories, etc.)? ______________________________

____

Does the client understand what is said in general conversation? ☐YES ☐NO. Comment: ______________

____

Does the client need frequent repetition or simplification during conversation? ☐YES ☐NO. Comment: ______

____

Can the client read? ☐YES ☐NO. Indicate current reading level: ______________________________

Can the client spell? ☐YES ☐NO. Indicate current spelling level: ______________________________

DAILY ROUTINE

School Name and District: ______________________________

School Address: ______________________________

Grade/Level: ______________________________

Type of Classroom (check all that apply): ☐Included in Regular Ed ☐Self Contained ☐Resource Room ☐Partially Included ☐Other: ______________________________

Support within Class/School Program: ☐ Full Time 1:1 Aide ☐ Part Time 1:1 Aide ☐ Classroom Aide ☐ Nurse ☐ Teacher ☐ Other: ______________________________

Please indicate number of minutes per week and location for each of these services:

Type of Service	Number of Minutes per Week	Location
Occupational Therapy		☐Home ☐Clinic ☐School
Physical Therapy		☐Home ☐Clinic ☐School
Speech Therapy		☐Home ☐Clinic ☐School
Developmental Therapy		☐Home ☐Clinic ☐School
Assistive Technology Services		☐Home ☐Clinic ☐School

If Clinic setting indicated above, name of Clinic and contact person: ______________________________

Anticipated changes in school placement or support services: ______________________________

Does your child have access to a computer within his/her educational program: ☐ YES ☐ NO

If YES, where is this computer located: ☐ Within Classroom ☐ Within LRC/Library ☐ Within Resource Room ☐ Other: ______________________________

What platform is this computer: ☐ PC with WIN ☐ Mac (specify operating system:______________________)

Does your child have access to a computer at home: ☐ YES ☐ NO

What platform is this computer: ☐ PC with WIN ☐ Mac (specify operating system:______________________)

FACILITATOR SUPPORT

Facilitators are significant people in the client's life who can take time to work with and provide support to the client on a day-to-day basis. Complete the following:

Name	Experience with Technical Devices	Amount of time available on a daily basis

TRANSPORTATION

Describe the client's usual means of transportation for the following situations:

To/from school or day program	
To/from recreational facilities	
Family/personal events	
Other:	

Please list activities that the client finds motivating/interesting? ***We need this information to help us prepare for a successful evaluation.*** ________________________________

____

____

In your own words, what information do you hope to obtain as a result of this evaluation:____________________

____

____

Please add any other information you feel is important: ________________________________

____

____

____

Has a picture of the client been attached? ☐YES ☐NO

(After completion, please return to the Assistive Technology Department at Easter Seals DuPage, Villa Park, IL)