COLUMBUS SPEECH & HEARING CENTER

We Improve Communication for Life

ADULT INTAKE QUESTIONNAIRE
FUNCTIONAL COMMUNICATION EVALUATION

Today's Date: _____

Name: _____ Date of Birth: _____

Person completing form and relationship to client: _____

GENERAL INFORMATION

1. What are your reasons for scheduling this appointment?

   _____

   _____

2. What do you feel are the client's strengths in terms of communication?

   _____

   _____

3. What are the client's current communication needs?

   _____

   _____

4. What are you currently doing that helps the client communicate more effectively?

   _____

   _____

5. Has the client previously received an evaluation and/or speech therapy?
   If so, where? _____
   For how long? _____
   Focus of treatment: _____
   Results of treatment: _____

6. What do you hope to gain from today's appointment?

   _____

   _____

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BACKGROUND INFORMATION

1. Latest educational institution attended: _____

2. Is the client currently employed or attending a workshop/day program? If yes, please list name of program and how often attended.

   _____

   _____

3. Current residential setting (i.e. group home, supported living, etc.) and name of agency, if applicable:

   _____

COMMUNICATION

1. Please indicate the level of independence for the following (Check One):

	Independent	Prompt-Dependent	N/A*
Initiates spoken communication with others (i.e. says "hello", says, "help me", starts conversations, etc.)	○	○	○
Uses sign language, gestures, or vocalizations to communicate	○	○	○
Follows simple 1-step directions (i.e. "go get your shoes", "get in the van", etc.)	○	○	○
Follows 2-step directions (i.e. "rinse off your plate and put it in the sink", "go get your shoes and put on your coat", etc.)	○	○	○
Responds appropriately to questions	○	○	○
Uses appropriate eye contact	○	○	○
Takes turns during conversation	○	○	○
Maintains appropriate personal space	○	○	○

*(i.e. non-verbal, sensory impairment, etc.)

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MEDICAL HISTORY

1. Does that client have a history of: (please check any that apply)

_____ seizures and/or convulsions _____ frequent colds and/or coughs
_____ serious head injuries _____ high fevers
_____ hearing difficulties _____ allergies
_____ eye difficulties _____ serious illnesses
_____ sinus problems _____ sore throats
_____ difficulty swallowing _____ noise exposure
_____ major surgery or hospitalization
If so, for what? _____ Date: _____
_____ psychological/psychiatric treatment
If so, for what? _____ Date: _____
_____major accidents
If so, please describe_____ Date: _____

2. Is the client currently under the care of a physician? YES _____ NO _____
If yes, please complete below.

Physician/Specialist Name: _____
Address: _____
City, State, Zip:_____

3. Has the client seen any other specialists? (counselor, neurologist, audiologist, etc.)
YES _____ NO _____
If yes, please complete below.

Physician/Specialist Name: _____
Address: _____
City, State, Zip: _____

4. Does the client have a diagnosed medical condition or cognitive disorder that is thought to be contributing to his/her communication difficulties?
YES _____ NO _____
If yes, please name the condition/disorder: _____
Please bring to the evaluation any diagnostic reports or other information related to this.