COLUMBUS SPEECH & HEARING
EST.1923

ADULT INTAKE QUESTIONNAIRE FUNCTIONAL COMMUNICATION EVALUATION

Name: _____

Today's Date: _____ 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 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? _____

BACKGROUND INFORMATION

Latest educational institution attended:_____

_____

_____

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

_____

_____

Current residential setting (e.g., group home, supported living, etc.) and name of the 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 (e.g., says, "hello," says, "help me," starts conversations, etc.).			
Uses sign language, gestures or vocalizations to communicate.			
Follows simple one-step directions (e.g., "go get your shoes," "get in the van," etc.).			
Follows two-step directions (e.g., "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.			

**(e.g., nonverbal, sensory impairment, etc.)*

MEDICAL HISTORY

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

_____ seizures or convulsions
_____ frequent colds 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: _____