Prairie REHABILITATION SERVICES

ALS CLINIC INTAKE INFORMATION FOR AAC

The AAC evaluation may include several visits. Additional therapy/intervention may be recommended. The person being referred should answer these questions, if possible. In addition, other team members, should provide input.

A: PERSONAL INFORMATION

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: ____ Height: _____ Weight: _____

□ Right handed □ Left handed

Diagnosis (circle): ALS-Bulbar ALS-Spinal ALS-Mixed ALS-unknown

Onset of ALS Diagnosis: _____

Do you currently have or have you previously had any of the diseases listed below?

Yes	No		If yes, when diagnosed
□	□	High blood pressure	_____
□	□	Diabetes	_____
□	□	Heart Disease	_____
□	□	Lung Disease	_____
□	□	Stomach Disorders (ulcer, etc.)	_____
□	□	Liver Disorders (hepatitis, etc.)	_____
□	□	HIV positive	_____
□	□	Kidney and Bladder Control	_____
□	□	Glands (thyroid, etc.)	_____
□	□	Skin Disease	_____
□	□	Cancer	_____
□	□	Fainting Spells	_____
□	□	Vision Problems (not glasses)	_____
□	□	Hearing Problems	_____
□	□	Depression	_____
□	□	Other Physical or Mental Health Diagnosis	_____

Do you have any allergies? □ Yes □ No If yes, please list _____

Are you currently taking any medications? □ Yes □ No If yes, please list _____

_____

_____

Non-Prescription Medications & Supplements: _____

_____

Referring Physician: _____

To Be Completed By Prairie Rehabilitation Services

Primary Communication Partner/s: _____

Hearing Status: _____

Communication Partner's Hearing Status: _____

Typical Communication Needs (circle all that apply):

person-to-person	teaching	to/with children
public speaking	small groups	telephone
email	internet	VOIP (etc.)
cell phone	text-messaging	Instant messaging

Current communication technology:

telephone (describe): _____
cell phone
computer wired or wireless?
current software (list): _____

What is your present problem with communication? Unintelligible Fatigue Frustration

Please list your goals for this evaluation: _____

Please list any alternative communication strategies previously tried:

gestures	P/C symbols
writing	sign language
mouthing words	speech generating device
eye gaze	

Physical Status (please check):	(Please circle)	(Please complete)
A: Positioning/Mobility		
____ wheelchair	Power / Manual	Hours per day: _____
____ walking	Alone / Assisted	Hours per day: _____
____ modified diet		
____ feeding tube when? _____	Yes / No	Hours per day: _____
____ Splint _____	Yes / No	Hours per day: _____
____ Casts	Yes / No	Hours per day: _____
____ Glasses	Yes / No	Hours per day: _____
____ Hearing Aides	Yes / No	Hours per day: _____

B. Motor Screening? Or just put a +, -
Can the person do the following:

____ Move head left	____ Move a single finger? (which?) _____
____ Move head right	____ Move lips
____ Move head up	____ Move jaw
____ Move head down	____ Move tongue
____ Move eyes up on command	____ Move shoulder
____ Move eyes down on command	____ Move foot
____ Follow objects up with eyes	____ Move eyebrows / forehead
____ Follow objects down with eyes	
____ Other:	

C. Comprehension: (Please check all that apply):
____ Follows one-step directions
____ Follows two-step directions
____ Follows three-step directions
____ Follows directions accurately
____ Makes choices