

201 I. U. Willets Rd., Albertson, NY 11507
Phone: 516/465-1626, Fax: 516/465-3744, www.kornreich.org

**ASSISTIVE TECHNOLOGY EVALUATION
SCREENING FORM - CONSUMER**

To be completed by you, the consumer, a family member, or someone in your personal life familiar with your need for assistive technology. This information will be used to help us prepare for your evaluation. If you have questions about how we use it, please ask us at any time. Please make your answers as SPECIFIC as possible; circle more than one choice when appropriate; feel free to write additional information in the margins and on additional paper. **The more we know about your abilities and goals, the more efficient your evaluation will be, and the better the result.**

Your last name: _____ First name: _____ Today's date: _____

Date of birth: _____ Male/Female Address: _____

Phone: _____ e-mail: _____

Person completing this form: self / parent (name) _____ / other (specify) _____

PURPOSE OF EVALUATION:

What kind of assistive technology are you seeking?
Augmentative communication / Computer access / Other (describe below)

IMPORTANT: Describe the problems assistive technology may help you with. What do you expect or hope assistive technology will enable you to do that you cannot do now? (Add additional paper as needed)

If you have any assistive technology now, describe it: _____

Do you use it? Yes /No If not, why not? _____

What problems (if any) do you have with it? _____

If you've had a previous assistive technology evaluation, state:

Date: _____ Where: _____

For what kind of technology?
Augmentative communication / Computer access / Other: _____

(If there was a written report, please attach a copy, or make arrangements for us to receive a copy.)

PERTINENT BACKGROUND INFORMATION

Diagnosis: _____ How long have you had this diagnosis? _____

If you take **medication**, what is it for? _____

List any **safety** issues we should know about (e.g., ventilator, seizures, etc.) _____

Any **vision** problems? (describe): _____ Glasses? Yes / No

Any **hearing** problems? (describe): _____ Hearing aid? Yes/No

Walking: Walk independently / Walk assisted (describe) _____ / Don't walk

Wheelchair: Power chair or scooter / Manual chair / None Self propel? Yes / No Laptray? Yes / No

If chair will be replaced soon, When? _____ Why? _____

Hand function: Right handed/Left handed Weakness, tremor, paralysis, or other problems?

(describe) _____

Can you: Hold a pen? Yes / No Feed yourself? Yes / No / Need help
Press buttons (as on a telephone)? Yes / No Comb your hair? Yes / No / Need help

Communication: Speech impairment? (describe) _____

What is your primary language? _____ Other language(s): _____

Cognition: Any problems with memory?: Short term / Long term
Any trouble following directions? Rarely or never / Occasionally / Often
Any trouble concentrating or sticking to a task? Rarely or never / Occasionally / Often

Education: Highest level completed: _____ In school now or soon? Yes / No
Do you have trouble: Reading? Yes / No Doing basic arithmetic? Yes / No
Do you have a learning disability? Yes / No What type? _____

Do you have a personal care attendant? Yes / No If so, how often? _____

When was the last time you received any:

Occupational therapy Never / Over a year ago / Less than a year ago / Receiving now or soon
Speech/language therapy Never / Over a year ago / Less than a year ago / Receiving now or soon
Physical therapy Never / Over a year ago / Less than a year ago / Receiving now or soon
Vocational eval./training Never / Over a year ago / Less than a year ago / Receiving now or soon
Other rehab/therapy Never / Over a year ago / Less than a year ago / Receiving now or soon

describe: _____

COMPUTER ACCESS SCREENING INFORMATION
To be completed ONLY by consumer seeking COMPUTER ACCESS services
(see next page for Augmentative Communication section)

What do you want to use a computer for?

Word processing /Graphics /Internet /Education /Other (specify): _____

Do you **own** a computer now? If so, what **type**? _____

How much **experience** do you have with personal computer applications?

Word processing	Almost none / A little / Quite a bit / A lot
Computer graphics	Almost none / A little / Quite a bit / A lot
Internet	Almost none / A little / Quite a bit / A lot
Educational programs	Almost none / A little / Quite a bit / A lot
Games	Almost none / A little / Quite a bit / A lot
Other: _____	Almost none / A little / Quite a bit / A lot

What SPECIFIC difficulties have you had (or do you expect to have) with using a computer because of your disability? (For example: arm gets tired; can't read screen; hit 2 keys at once ; mouse moves when pressing button; etc.) **Describe ALL difficulties:**

Describe any **special computer equipment** or software you have used because of your disability (For example: special keyboard, left-handed mouse, typing stick, keyboard tray; talking word processor, etc.)

Do you have **pain** when you use a computer? Don't know/No/Yes (where): _____

How long before pain starts? _____ How long before you stop due to pain? _____

Have you been treated for the pain? No / Yes What does the doctor say? _____

Where will you use the computer? (circle all that apply)

A) Home / Work / School / Other _____

B) Lying on bed, couch /Standing /Office chair /Kitchen-type chair /Easy chair, couch /Wheelchair

C) Computer will be on: A desk / A table / In lap / A computer workstation / On laptray

AUGMENTATIVE COMMUNICATION SCREENING INFORMATION

To be completed ONLY by consumer seeking AUGMENTATIVE COMMUNICATION services

(see previous page for Computer Access section)

Current methods of communication (circle all that apply):

- Speech
- Yes-no responses
- Gestures, facial expressions
- Manual communication board
- Electronic communication device (name) _____
- Other: _____
- Sounds
- Sign language
- Writing
- Eye gaze

Who can **understand** your communication, and how well?

- Strangers Nearly always / Part of the time / Almost never / (not applicable)
- Teachers Nearly always / Part of the time / Almost never / (not applicable)
- Peers, friends Nearly always / Part of the time / Almost never / (not applicable)
- Parents Nearly always / Part of the time / Almost never / (not applicable)
- Siblings Nearly always / Part of the time / Almost never / (not applicable)
- Other Nearly always / Part of the time / Almost never / (not applicable)

What do you do when you are **not understood** (circle all that apply)?

- Keep trying to communicate same message
- Get angry
- Stop trying to communicate
- Change message to make yourself understood
- Get someone who understands you to translate
- Other: _____

Does your communication problem affect your: Social life? / Work or school life? / Family life?

Describe the **effect**: _____

If you have an electronic communication device:

Do you use it? Yes /No If not, why not? What problems (if any) do you have with it?
