



Bonnie Vaillancourt M.S. CCC-SLP
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AAC • Consultation • Diagnostics • Therapy

Client History Questionnaire

Name of Person completing form:	Relationship to Client:
Date form Completed:	
Client Name:	Date of Birth:
	Sex: M F
Physical Address:	
Mailing Address : (if different)	
Parent or Guardian Name:	
Home Phone Number:	Cell Phone Number:
Email Address:	
Physical Address:	
Mailing Address : (if different)	
Agency or School District Name:	
Physical Address:	
Mailing Address: (if different)	
Contact Person's Name:	Title:
Email address:	Office Phone Number:



3.Has the client ever had speech and language therapy?	Yes	No
If so where and when?		
4.Does the client currently use an Augmentative Alternative Communication (AAC) device?		
If yes, what type of device and for how long has he/she used it?		
5. Is the client aware of or frustrated by, any speech and language difficulties? Yes No		
6. If yes, what do these frustrations look like?		
7.What do you see as the client's most difficult problem at home?		
8.What do you see as the client's most difficult problem at school setting?		
9. What are your goals for the speech and language evaluation and/or speech and language therapy (if applicable) ?		
10. Any additional information:		