Speech, Language, and Hearing Clinic
Department of Communication Sciences and Disorders
The Pennsylvania State University
110 Ford Building
University Park, PA 16802-3000

Clinic: 814-865-5414
Voice/TDD
Fax: 814-863-3759

Adult Case History Information

The Cost of the initial speech and language assessment is $*150.00 (unless you are a Penn State student – in this case there is no charge for the assessment)* which includes the assessment, the discussion of assessment results and recommendations, and a written report. Payment should be discussed with the Clinical Administrative Support Assistant prior to your appointment, but generally will be due on the day of the assessment. The Penn State Speech, Language, and Hearing Clinic does bill a few (but not all) insurance companies. For those clients who are insured through companies we do not directly bill, you will be provided with a copy of the billing information which will include the fee paid, the diagnosis and the code for that diagnosis. If you wish to pursue reimbursement, you can then submit the claim to your insurance company directly.

The Penn State Speech, Language, and Hearing Clinic is not a Medicaid/Medical Assistance provider. Therefore, we are not able to accept referrals that are affiliated with any Medical Assistance plans. If you plan to schedule the assessment, you will be responsible for payment the day of the assessment.

For clients covered by Geisinger Health Plan (GHP): Prior to the assessment you will need to ask your physician for a referral letter and prescription for a speech/language evaluation. The referral letter, prescription, and insurance card must be provided to the Clinical Administrative Support Assistant at the Penn State Speech, Language, and Hearing Clinic at least two weeks prior to the assessment to insure authorization of the services by GHP. You may fax this documentation to 814-863-3759, or deliver the documents to 110 Ford Building, University Park, PA 16802. The clinic will bill GHP directly. It is likely that your GHP policy will require a co-pay payment. This co-pay will be collected at the time of the assessment.

In preparation for your speech-language evaluation, please answer the questions on the attached Case History form, and return this form to the Penn State Speech, Language, and Hearing Clinic at 110 Ford Building, University Park, PA 16802 or fax to 814-863-3759. The information you provide on this form is confidential and will aid us in planning a thorough evaluation.

Date: _____

Person to be evaluated:

Name: _____ Date of Birth: _____
Address: _____ Present Age: _____
_____ Gender: _____
Phone: (___) _____ Email Address: _____

Person filling out this form (if different from the person to be evaluated)

Name: _____
Relationship to person being evaluated: _____

Person who suggested this evaluation:

Name: _____ Phone: _____
Address: _____

Family Information:

Father's Name: _____ Occupation: _____ Age:
Mother's Name: _____ Occupation: _____ Age:
Wife/Husband's Name: _____ Occupation: _____ Age: _____
Children's Names and Ages: _____
_____

Family member or other individual to contact for additional information:

Name: _____ Phone during day: _____
Address: _____ Phone during evening:
_____
_____ Relationship to person being evaluated: _____
_____

If anyone else in your family has had a speech/language or hearing problem, please tell who it is and briefly describe the problem:

_____
_____
_____

Medical History

1. Present Physical Status—Please check if you now have any of the following conditions, note when they first occurred, and explain briefly.

	Yes	When it occurred	Explanation
a. Vision Problem	_____	_____	_____
b. Hearing Problem	_____	_____	_____
c. Problems Swallowing/ Choking	_____	_____	_____
d. Disability	_____	_____	_____
e. Dizziness/Loss of Balance	_____	_____	_____
f. Seizures	_____	_____	_____
g. Chronic Physical Problems (allergies, heart condition, frequent colds, migraine headaches, etc.)	_____	_____	_____
h. Other conditions	_____	_____	_____

i. Please list all medicines which you take regularly: _____

_____

j. Which of the above conditions, if any, interfere with your working? _____

_____

2. Please check if you have had any of the following conditions in the past, note when they first occurred and explain briefly.

	Yes	When it occurred	Explanation
a. Seizures	_____	_____	_____
b. High Fevers	_____	_____	_____
c. Serious Illness	_____	_____	_____
d. Operations	_____	_____	_____
e. Accidents	_____	_____	_____
f. Dizziness/Loss of Balance	_____	_____	_____
g. Loss of Consciousness	_____	_____	_____
h. Other Conditions	_____	_____	_____
i. Were there any problems associated with your birth?	_____	_____	_____

Educational/Vocational Information

1. What was the highest educational level you completed?_____Year Completed: _____
2. Are you still in school? Yes_____ No _____
3. Name and address of last school attended: _____

4. If you have ever worked or are now working, please complete this section.
   a. What types of jobs have you held in the past?_____

   b. What type of job do you have now? _____

   c. How long have you had your present job? _____

Communication Information

1. Please describe the speech/language/hearing difficulty which you now have:

2. Please tell when the difficulty began and how, or under what conditions, it began:

3. Has the problem changed (gotten better or worse) since it first began? Describe the changes which have taken place.

4. How do other people react to your speech/language/hearing problem?

5. Does your speech/language/hearing problem vary in different situations? If so, how?

6. Are you concerned about your speech/language/hearing problem? If so, what are your concerns?

_____
_____
_____
_____

7. What have you done to try to help overcome your problem?

_____
_____
_____
_____

8. What do you hope to find out from this evaluation?

_____
_____
_____
_____

9. Please list information about previous testing and evaluations related to your problem:

Approximate Date	Place	Person Who Evaluated You	Information You Received

10. Please list information about previous therapy you have received:

Approximate Date	Place	Person Who Provided Therapy	How was it Helpful

Thank you for providing the above information.