Adult Case History Information

The Cost of the initial speech and language assessment is $75.00 (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.
Person to be evaluated:

Name: ____________________________ Date of Birth: ____________________________
Address: __________________________ Present Age: ____________________________
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: _______________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>When it occurred</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Vision Problem</td>
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<tr>
<td>b. Hearing Problem</td>
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<td>c. Problems</td>
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<tr>
<td>Swallowing/Choking</td>
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<td>d. Disability</td>
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<tr>
<td>e. Dizziness/Loss of Balance</td>
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<tr>
<td>f. Seizures</td>
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<td>g. Chronic Physical Problems</td>
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<tr>
<td>(allergies, heart condition, frequent colds, migraine headaches, etc.)</td>
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<tr>
<td>h. Other conditions</td>
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<tr>
<td>i. Please list all medicines which you take regularly:</td>
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<td>j. Which of the above conditions, if any, interfere with your working?</td>
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</table>

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>When it occurred</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Seizures</td>
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<tr>
<td>b. High Fevers</td>
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<td>c. Serious Illness</td>
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<td>d. Operations</td>
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<tr>
<td>e. Accidents</td>
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<td>f. Dizziness/Loss of Balance</td>
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<td>g. Loss of Consciousness</td>
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<tr>
<td>h. Other Conditions</td>
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<tr>
<td>i. Were there any problems associated with your birth?</td>
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</table>
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:

<table>
<thead>
<tr>
<th>Approximate Date</th>
<th>Place</th>
<th>Person Who Evaluated You</th>
<th>Information You Received</th>
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10. Please list information about previous therapy you have received:

<table>
<thead>
<tr>
<th>Approximate Date</th>
<th>Place</th>
<th>Person Who Provided Therapy</th>
<th>How was it Helpful</th>
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Thank you for providing the above information.