Speech, Language, and Hearing Clinic
Department of Communication Sciences and Disorders **Clinic: 814-865-5414**
The Pennsylvania State University **Voice/TDD**
114 Research Center A
University Park, PA 16802-3000 **Fax: 814-863-3759**

Adult Case History Information

The cost of the initial communication 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 ensure authorization of the services by GHP. You may fax this documentation to 814-863-3759, or deliver the documents to 114 Research Center A, 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-payment will be collected at the time of the assessment.

In preparation for your communication assessment, please answer the questions on the attached Case History form, and return this form to the Penn State Speech, Language, and Hearing Clinic at 114 Research Center A, 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

Legal Name: ____

Preferred Name: (if different) ______________________________ Date of Birth: ______________

Address: _____________________________ Present Age: _______________

_____________________________________ Gender: __________________

Phone: ______________________________ Pronouns: _________________

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

Partner's/Wife's/Husband's Name:

____

Children's Names and Ages: ____

____

Family member or other individual to contact for additional information:

Name: _____________________________ Phone during day: _______________________________

Phone during evening: ___________________________

Address: ____

Relationship to person being evaluated: ____

Medical History:

1. Medical Diagnosis/Diagnoses:
   ____
   ____
   ____

2. 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 medications which you take regularly:
   ____
   ____

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

3. 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. Seizure	_____	________________	____________________
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?	_____	________________	____________________

4. Current medications: ____
   ____
   ____

Educational/Vocational Information:

1. What was the highest educational level you completed? ___________ Year completed: _________
2. Are you still in school? Yes ________ No ________
3. Last school attended: ____

   ____

4. If you have ever worked or are now working, please complete this section.
   a. What type 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, communication difference or communication concern: ____

   ____

   ____

   ____

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

   ____

   ____

3. Has the problem, difference or concern 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 difference or concern?

   ____

   ____

   ____

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

   ____

   ____

6. Are you worried about your speech/language/hearing problem difference or concern? If so, what are your worries? ____

   ____

   ____

7. What have you done to try to help overcome your problem, difference or concern? ___________
____
____

8. What do you hope to find out from an evaluation? ________________________________
____
____

9. Please list information about previous testing and evaluations related to your problem, difference or concern:

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 Evaluated you**	**How was it Helpful**
_____________	_____________	_______________________	_________________________
_____________	_____________	_______________________	_________________________
_____________	_____________	_______________________	_________________________

Medical Insurance Information

Name of Insurance Company: ____

Medicare: __________yes __________no

Name of policy holder: ____

Policy number: __________________________ Group number: _______________________________

Thank you for providing the above information.