



Adult History Information

Cost of the assessment is \$75.00, (unless you are a PSU 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 made the day of the assessment. With the exception of Geisinger Health Plan (GHP), the PSU clinic does not bill insurance companies, primarily because insurance companies in general do not reimburse for this service. You will be provided with a copy of the billing sheet(s) that includes the fee paid, the diagnosis and the code for that diagnosis. You can submit that to your insurance company if you wish to pursue reimbursement.

The Penn State Speech 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.

If you are covered by GHP, prior to the assessment, you will need to ask your physician for a referral letter/note for a speech/language evaluation. The referral letter and insurance card need to be provided to Dawn Williams, Staff Assistant and Clinic Receptionist, at the Penn State Speech and Hearing Clinic, at least two weeks prior to the assessment to ensure authorization of the services by GHP. Copies of the referral letter and insurance card can be faxed to [814- 863-3759](tel:814-863-3759) or e-mailed to ddw16@psu.edu, care of Dawn Williams, 110 Ford Building, University Park, PA 16802. You may also hand deliver these copies directly to Ms. Williams at the Clinic reception desk in 110 Ford Building. We will bill GHP directly. It is likely that your GHP policy will require a co-pay payment which is expected to be paid at the time of the assessment.

In preparation for your speech-language evaluation, please answer the questions below and return this form to the Penn State Speech and Hearing Clinic @ 110 Ford Building, University Park, PA 16802 or fax to 814-863-3759. This information is confidential and will aid us in planning a more thorough evaluation.

Date: _____

Person to be evaluated:

Name: _____ Date of Birth: _____
Address: _____ Present Age: _____
Phone: () _____ Gender: _____
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
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<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>
<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>

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

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