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 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:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

2 Adult History Info #2 - 2014
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>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. Hearing Problem</td>
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<td></td>
<td></td>
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<tr>
<td>c. Problems</td>
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<td></td>
<td></td>
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<tr>
<td>d. Disability</td>
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<td></td>
<td></td>
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<tr>
<td>e. Dizziness/Loss of Balance</td>
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<td></td>
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<tr>
<td>f. Seizures</td>
<td></td>
<td></td>
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<tr>
<td>g. Chronic Physical Problems</td>
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<td></td>
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<tr>
<td>(allergies, heart condition, frequent colds, migraine headaches, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Other conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Please list all medicines which you take regularly:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Which of the above conditions, if any, interfere with your working?</td>
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</tbody>
</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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<tr>
<td>d. Operations</td>
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<td></td>
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<tr>
<td>e. Accidents</td>
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<td></td>
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<tr>
<td>f. Dizziness/Loss of Balance</td>
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<tr>
<td>g. Loss of Consciousness</td>
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<tr>
<td>h. Other Conditions</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>i. Were there any problems associated with your birth?</td>
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</tbody>
</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>
</tr>
</thead>
<tbody>
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</table>

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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<tbody>
<tr>
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Thank you for providing the above information.