**Medicare Patient – Therapy Questionnaire**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_**

**Please answer each of the following questions by circling YES or NO and completing the requested information:**

Yes No 1. Are you currently receiving both Physical Therapy and Speech Language

Pathology Services? If Yes, Name of the other therapy provider:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No 2. Are you currently receiving any Home Health Services (including nursing,

bathing or dressing assistance, injections or respiratory services)?

If Yes, what type of Home Health Services are your receiving?

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Yes No 3. I am covered by Medicare and it is because I am:

□ 65 or older □ Under 65 & disabled Official Retirement Date \_\_\_/\_\_\_/\_\_\_

□ Over 65 and have ERSD and on disability □ Under 65 and have ERSD

Yes No 4. Are you currently receiving Black Lung Benefits?

Yes No 5. Is your ailment due to: □ Motor Vehicle Accident □ Work-related Injury □ Liability

Yes No 6. Do you need to use any special medical equipment as a result of your current

problem?

Yes No 7. Since the onset of this current problem, has the need for assistance from

family or friends increased?

Yes No 8. a. Has this current problem resulted in the need to change your living situation?

Yes No 8. b. If Yes, is this therapy necessary in order to return to your previous living

situation?

9. What type of home environment do you live in **now** (private home, assisted

living, etc.)?

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10. What type of home environment do you **plan to** live in when you complete this

therapy (private home, assisted living, etc.)?

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11. Who do you live with (or intend to live with) when you complete this therapy?

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Yes No 12. Have you had 2 or more falls in the past year or any fall with injury in the past

year?

Yes No 13. Are you in need of therapy services as a result of a fall?

Yes No 14. Are you currently having difficulty with walking, balance or fear of falling?

**Thank you for completing this questionnaire. The information above will assist your therapist in providing you the therapy treatment that you need.**