FRONT RANGE ORTHOPEDICS & SPINE

PHYSICAL THERAPY

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 you receiving?

_____

Name of the Agency: _____

Date of Last Service: _____

Yes No 3. Do you need to use any special medical equipment as a result of your current problem?

Yes No 4. Since the onset of this current problem, has the need for assistance from family or friends increased?

Yes No 5.Has this current problem resulted in the need to change your living situation?

Yes No 5.a. If yes, is this therapy necessary in order to return to your previous living situation?

6. What type of home environment do you live in **now** (private home, assisted living, etc.)?

_____

7. What type of home environment do you **plan to** live in when you complete this therapy (private home, assisted living, etc.)?

_____

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

_____

Yes No 9. Have you had 2 or more falls in the past year or any fall with injury in the past year?

Yes No 10. Are you in need of therapy services as a result of a fall?

Yes No 11. 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.

_____ _____

Patient Signature **Date** **Therapist Signature** **Date**