Personalized Therapy, LLC

Occupational & Physical Therapy for Children & Adults

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. Have you been discharged from a hospital or Skilled Nursing Facility (SNF) within the past 30 days?

If yes, Date of Discharge: ____

Name of Hospital or Skilled Nursing Facility: _____________________________________

Yes No 2. Have you received similar therapy services for **this problem** in the past? If yes, please provide the following information

Date(s) of therapy: ____

Provider Name: ____

Services Provided: ____

Yes No 3. Have you received therapy services for **other problems/conditions during 2011**? If yes, please provide the following information

Date(s) of therapy: ____

Provider Name: ____

Services Provided: ____

Yes No 4. Are you currently receiving **both** Physical Therapy and Speech Language Pathology Services? If yes, Name of the other therapy provider: ____

Yes No 5. Do you have a condition that affects multiple areas that you feel will affect your ability to recover from the problem you are receiving therapy for?

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

Yes No 7. Has this current problem resulted in the need to change your living situation?

Yes No 7a. If yes, is this therapy necessary in order to return to your previous living situation?

Yes No 8. Since the onset of this current problem, has the need for assistance from family or friends increased?

Yes No 9. Is this therapy necessary in order to return to your previous level of independence with activities of daily living? (i.e.: bathing dressing, eating)

10. At the present time, would you say your health is (circle one)

    Excellent Very Good Fair Poor

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

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

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

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

____ ____

Signature Date

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