Medicare Therapy Questionnaire

Name: _____Date:_____ Date of Birth:_____

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 recently?
If yes, Date of Discharge:_____
Name of facility:_____

YES NO 2. Have you received similar therapy services for ***your current problem*** in the past?
Dates of Therapy:_____
Provider name: _____
Services provided:_____

YES NO 3. Have you received therapy services ***for other problems/conditions*** during the past year?
Dates of Therapy:_____
Provider name: _____
Services provided:_____

YES NO 4. Have you received Speech Language Pathology services in the past year?

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

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 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 (eating, bathing, dressing, driving, walking)?

YES NO 10. Describe your current level of health (circle one):

EXCELLENT VERY GOOD FAIR POOR

11. Describe your home living environment (circle one):

PRIVATE HOME INDEPENDENTLY PRIVATE HOME WITH ASSISTANCE
ASSISTED LIVING FACILITY

12. What type of home environment do you plan to live in after completing therapy?

PRIVATE HOME INDEPENDENTLY PRIVATE HOME WITH ASSISTANCE
ASSISTED LIVING FACILITY