# Medicare Patient – Therapy Questionnaire

**Name:** ______________________________ **Date of Birth:** ________________ **Age:** __________

**Please answer each of the following questions by c\ YW]b[ 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. Do you need to use any special medical equipment as a result of your current problem?

Yes No 3. Since the onset of this current problem, has the need for assistance from family or friends increased?

Yes No 4. Has this current problem resulted in the need to change your living situation?

Yes No 4.a. If yes, is this therapy necessary in order to return to your previous living situation?

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

_____________________________________________________________________

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

_____________________________________________________________________

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

_____________________________________________________________________

Yes No 8. Are you currently receiving <u>any</u> Home Health Services (including nursing, bathing or dressing assistance, injections or respiratory services)?

_____________________________________________________________________

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**

**Revised January 1, 2010**