Medicare Intake Form

Date: ____________________

Name: ________________________________ **D.O.B.:** ____________________

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1. Have you been discharged from a hospital or skilled nursing facility within the last 30 days?

_____ Yes _____ No If yes, explain: ____

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2. Do you have other conditions or diseases that may affect your ability to recover from your current problem?

_____ Yes _____ No If yes, list conditions or diseases: ____________________________

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3. Do you have any mental or cognitive problems that may affect your ability to participate in therapy? Ex: memory loss, short attention span, etc.

_____ Yes _____ No If yes, list conditions: ________________________________

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4. Have you had physical or speech therapy services within this calendar year for a different problem?

_____ Yes _____ No If yes, when, where and for what diagnosis: ____________________

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5. Are you presently receiving speech therapy services for the same condition for which you are presently seeking physical therapy?

_____ Yes _____ No

6. Are you living in a different setting than usual because of the condition that you are being treated for in physical therapy?

_____ Yes _____ No

7. Are you requiring assistance with daily living activities because of the condition for which you are seeking physical therapy?

_____ Yes _____ No

What level of assistance did you require prior to the onset of your current condition?

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8. Do you have access to a hospital based therapy department?

_____ Yes _____ No

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Patient Signature