Ascend physical therapy & wellness

Medicare Intake Form

Name: _____ Date of birth: _____

Have you been discharged from a hospital or skilled nursing facility within the last 30 days?
Yes / No If yes, explain: _____

_____

Do you have any conditions or diseases that may affect your ability to recover from your current problem? **Yes / No** If yes, list conditions or diseases: _____

_____

Do you have any mental or cognitive problems that may affect your ability to participate in therapy? E.g., memory loss, short attention span, etc… **Yes / No** If yes, list conditions:

_____

_____

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?_____

_____

Are you presently receiving speech therapy services for the same condition for which you are presently seeking physical therapy? **Yes / No**

Are you living in a different setting than usual because of the condition for which you are seeking physical therapy? **Yes / No**

Are you requiring assistance with daily living activities because of the condition for which you are currently seeking physical therapy services? **Yes / No**

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

_____

Are you currently receiving any for of Home Health Services being paid for by your insurance?
Yes / No If yes, when is your expected discharge date?: _____

<u>*YOU MUST BE DISCHARGED FROM HOME HEALTH PRIOR TO BEING SEEN TODAY.</u>

Patient Signature:_____ Date _____