PRO IMPACT
PHYSICAL THERAPY • SPORTS PERFORMANCE

Medicare Patient – Therapy Questionnaire

Name:_____ **Date of Birth:**_____ **Age:**_____

Please answer each of the following questions by checking 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 4a. 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?

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

_____ _____

Patient Signature **Date** **Therapist Signature** **Date**