

MEDICARE NEW EPISODE/CASE FORM (Please Print)

First Name: _____ Last Name: _____ DOB: _____ Age: _____

Medical Information for this episode of care:

Referring Physician: _____ Primary Care Physician: _____

What part of your body will we be treating? _____

When did your symptoms start, or date of your injury? _____

How did your injury occur? _____

If you've had surgery for this, what was the date of your most recent surgery? _____

Have you seen any other provider within the last 30 days for this condition? (i.e. massage therapist, chiropractor, athletic trainer or acupuncturist) _____

Have you had any diagnostic tests completed? MRI X-Ray Please list any other tests _____

Are you working? Yes No If working, has this injury restricted you from employment? Yes No
If yes, Restricted or Off Work
If yes, what is your occupation? _____

Pain, when did pain first start _____

At present time, would you say that your health is: Excellent Very Good Fair Poor

Have you fallen more than 2 times in the past year: Yes No

Have you had any falls with injuries in the past year: Yes No

Have you used any tobacco products at least once in the past 24 months? Yes No

*Are you currently receiving any health-related services at your home (home health nurse or aide)? Yes No
If yes, with what agency: _____

*Have you received any physical or occupational therapy in the past 60 days? This includes at a hospital, rehab center, nursing home, and/or in your home. Yes No

*Where do you live (or intend to live) at the conclusion of this outpatient therapy episode?
Private Home Private Apartment Rented Room Group Home Board & Care Apartment Assisted Living
Skilled Nursing Facility Other _____

*Who do you live with (or intend to live with) at the conclusion of this outpatient therapy episode?
Live Alone Spouse/Significant Other Child/Children Other Relative Unrelated person(s)
Personal Care Attendant Other _____