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 30days 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 _____