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 www.BristolPhysicalTherapyLLC.com

**Medicare Patient Information form (required by Medicare)**

Name: \_\_\_\_\_ Date \_\_\_\_\_

1) Since the beginning of this year have you had PT, Chiropractic or Speech therapy? \_\_\_\_ If yes, where?

2) Height (current) \_\_\_\_\_ (at your tallest) \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_

3) Medications

Medication name	Dose	Times/day	Date started	Oral, patch, inhale, injection,

4) Do you have a pain-related problem? yes \_\_\_\_\_ no \_\_\_\_\_

Body locations	Kind of pain?( dull, sharp, ache, burn, stab, pinch, etc)	When did it first start?	How much of the day do you have it?

How strong is your pain at its worst (in the last 48 hr)?

(no hurt) 0	(hurts a little) 1-2	(discomforting) 3-4	(distressing) 5-6	(horrible) 7-8	(excruciating) 9-10

How strong is your pain at its least (in the past 48 hr)?

(no hurt) 0	(hurts a little) 1-2	(discomforting) 3-4	(distressing) 5-6	(horrible) 7-8	(excruciating) 9-10

5) Have you fallen and hurt yourself within the past year? yes \_\_\_\_\_ no \_\_\_\_\_

6) Have you fallen 2 or more times without hurting yourself in the past year? yes \_\_\_\_\_ no \_\_\_\_\_

I certify that I understand these questions and have answered them truthfully:

Name: \_\_\_\_\_ Date \_\_\_\_\_

(Patient Signature)