Bristol Physical Therapy, LLC

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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 last 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)