FYZICAL Therapy & Balance Centers

Patient Name: _____

Date: _____

Medicare Questionnaire

Medicare Beneficiaries Over age 65

1. Are you currently working full or part-time? Yes _____ No _____
2. Are you married? Yes _____ No _____
   a. If so, does your spouse work full or part-time? Yes _____ No _____
   b. If yes, how many employees does your employer or spouse's employer have? Yes _____ No _____
3. Are you covered under an employer group health plan based on your current employment, or current employment of a spouse? Yes _____ No _____
4. Are you entitled to Black Lung Medical Benefits? (i.e. As a result of working in a coal mine.) Yes _____ No _____
5. Was this service for the treatment of a work-related injury? Yes _____ No _____
6. Was this service for the treatment of an illness or injury which resulted from an auto/other accident? Yes _____ No _____
7. Are the service to be paid by a government program such as a research grant? Yes _____ No _____
8. Has the department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? Yes _____ No _____

Screening for Future Fall Risk

Medicare defines a fall as a sudden, unintentional change in position causing you to land at a lower level, on an object, the floor or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure or overwhelming external force.

1. Have you had two or more falls in the past year? Yes _____ No _____
2. Have you had any fall resulting in injury in the past year? Yes _____ No _____

Home Health

Have you received **ANY** Home Health Care in the last 60 days, this includes any provider physically coming to your house to perform any service/s? **Circle one.**

YES **NO**

IF YES, provide last date of service: _____

Name of Agency: _____

Telephone Number: _____

_____ _____

Patient Signature FYZICAL Staff Signature

For office use only

_____ Called Home Health Agency to confirm Discharge Date.

_____ Spoke to _____ at _____

_____ Patient Discharged on _____