

I. Administrative Information

Office Staff: Please complete this information before providing this questionnaire to the patient or to whomever is helping them.

A.1 Current Date / /
MM DD YYYY

A.2 **Names and National Provider Identification Codes (NPI) for therapists billing separately**
 Please enter the names and NPIs of therapists treating this patient in this clinic who bill Medicare separately. Each therapist who bills Medicare separately must complete their own separate "Provider Information" sections.

Therapist Name	Therapist NPI
A.2.a <input type="text"/>	A.3.a <input type="text"/>
A.2.b <input type="text"/>	A.3.b <input type="text"/>
A.2.c <input type="text"/>	A.3.c <input type="text"/>
A.2.d <input type="text"/>	A.3.d <input type="text"/>

A.4 Patient's Medicare Health Insurance Claim Number

A.5 **Does the patient need someone to assist them to complete the form, or answer for them?**
 There are several items in this questionnaire intended to be reported by patients. However, some patients may need assistance to fill out the form, and others may need someone to fill the form out for them.

A.5a **Based on your knowledge of the patient or conversations you have had with him or her, please indicate whether the patient may need assistance completing the form or needs to have someone else complete the form for them. Please check all that apply.**

- | | |
|--|---|
| <input type="checkbox"/> 1. The patient cannot read English or Spanish.
<input type="checkbox"/> 2. The patient has low vision or blindness.
<input type="checkbox"/> 3. The patient cannot write their own responses on the form (e.g., upper limb impairment).
<input type="checkbox"/> 4. The patient has difficulty understanding instructions.
<input type="checkbox"/> 5. The patient cannot concentrate for 15 minutes.
<input type="checkbox"/> 6. The patient cannot give correct/accurate answers to questions about their health.
<input type="checkbox"/> 7. Another reason:
<input type="text"/> | <input type="checkbox"/> 8. The patient does not need any assistance and can complete the questionnaire themselves. |
|--|---|

If a patient meets any of the above conditions, please choose an assistant or proxy to help the patient answer the questionnaire from the following list:

1. Family member or friend who came to the appointment with the patient
2. Treating therapist
3. Other office staff (**ONLY** if the patient appears to need an assistant to write down answers on the form, **NOT** if they appear to need a proxy to answer for them)

Please go in order down the list to choose an assistant or proxy. For example, if someone who came with the patient cannot help, please have the treating therapist help the patient with the questionnaire.

A.5b **Who completed this form?**

Patient
 Proxy/Assistant: Family Member Companion Not Family Therapist Other Office/Practice Staff

FOR OFFICE USE ONLY

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

II. Patient Information

Patients: Please complete this form before meeting with your therapist.

B.1a	First Name	B.1b	Middle Initial	B.1c	Last Name
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B.2	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	B.3	Birth Date	_ _ / _ _ / _ _ _ _
					MM DD YYYY

B.4 Race/Ethnicity (Check all that apply.)

Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> a. American Indian or Alaska Native | <input type="checkbox"/> e. Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> b. Asian | <input type="checkbox"/> f. White |
| <input type="checkbox"/> c. Black or African American | <input type="checkbox"/> g. Unknown |
| <input type="checkbox"/> d. Hispanic or Latino | |

B.5	Education (Check one box)	<input type="checkbox"/> Less than high school diploma	<input type="checkbox"/> High school graduate
		<input type="checkbox"/> Some college – no degree	<input type="checkbox"/> College or more

C.1 Primary Condition

What are the main health conditions for which/reasons why you are receiving therapy? Check all that apply.

Check all that apply.

Problems of the muscles, ligaments, joints and/or bones

- | | |
|--|---|
| <input type="checkbox"/> a. General | <input type="checkbox"/> f. Knee, leg, and/or foot |
| <input type="checkbox"/> b. Head and/or neck | <input type="checkbox"/> g. Shoulder |
| <input type="checkbox"/> c. Back and/or pelvis | <input type="checkbox"/> h. Elbow |
| <input type="checkbox"/> d. Ribs and/or collarbone | <input type="checkbox"/> i. Wrist, hand, and/or fingers |
| <input type="checkbox"/> e. Hip | |
- Other problems:**
- | | |
|---|--|
| <input type="checkbox"/> j. General weakness | <input type="checkbox"/> p. Wound and/or skin problem |
| <input type="checkbox"/> k. Problem with walking or balance | <input type="checkbox"/> q. Mental health condition |
| <input type="checkbox"/> l. Problem of the heart and/or blood vessels | <input type="checkbox"/> r. Cancer |
| <input type="checkbox"/> m. Problem of the lungs and/or breathing | <input type="checkbox"/> s. Communication, voice, or speech disorder |
| <input type="checkbox"/> n. Problem of the nervous system | <input type="checkbox"/> t. Swallowing disorder |
| <input type="checkbox"/> o. Problems with eyes, inner ear, or ears | <input type="checkbox"/> u. Other condition(s) |

C.2 How long ago did the health conditions/reasons for which you were being treated begin?

- | | |
|--|---|
| <input type="checkbox"/> Within a week | <input type="checkbox"/> Within the last 3 months |
| <input type="checkbox"/> Within the last month | <input type="checkbox"/> More than 3 months ago |

C.3 Surgical Status

a. Indicate the number of surgeries you have had in the past for the main condition for which/reason why you are receiving therapy.

- None 1 2 3 4 or more

b. When was your most recent surgery for the condition for which you are receiving therapy?

- | | |
|--|---|
| <input type="checkbox"/> Within the last week | <input type="checkbox"/> Within the last 3 months |
| <input type="checkbox"/> Within the last month | <input type="checkbox"/> More than 3 months ago |

II. Patient Information (cont.)

C.5 Other Medical Conditions

Has a doctor or other health professional ever told you that you have any of the following conditions? Please check all that apply.

Check all that apply.

- a. Arthritis (rheumatoid and/or osteoarthritis)
- b. Osteoporosis
- c. Asthma
- d. Chronic obstructive pulmonary disease (COPD), acquired respiratory distress syndrome (ARDS), emphysema, or asthma
- e. Chest pain from your heart (such as angina, irregular heart rhythm, or valve problems)
- f. Difficulty breathing or swelling in your legs because of your heart (such as congestive heart failure)
- g. Heart attack (myocardial infarct)
- h. Multiple sclerosis (MS), Parkinson's, or any other neurological condition
- i. Stroke or transischemic attack (TIA)
- j. Peripheral vascular condition, peripheral artery disease (PAD), or blood disorders
- k. Diabetes
- l. Ulcer, hernia, reflux, or any other upper gastrointestinal condition
- m. Depression
- n. Anxiety or panic disorders
- o. Cataracts, glaucoma, macular degeneration, loss of visual field, or any other visual impairment
- p. Spine/back problem, spinal stenosis, severe chronic back pain, or any other degenerative disc condition
- q. High blood pressure
- r. Headaches
- s. Kidney, bladder, prostate, or urination problems
- t. Allergies
- u. Incontinence
- v. Hepatitis
- w. HIV/AIDS
- x. Prostheses or implants
- y. Sleep dysfunction
- z. Cancer
- aa. Other disorders: *Please write in* _____

II. Patient Information (cont.)

E. Pain or Hurting

E.1 Pain Presence or Hurting

Have you had pain or hurting at any time during the last 7 days? If "no," please skip to the next page.

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E.2 Pain or Hurting Severity (Check one box.)

Please rate your worst pain during the last 7 days from 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain					Worst Pain

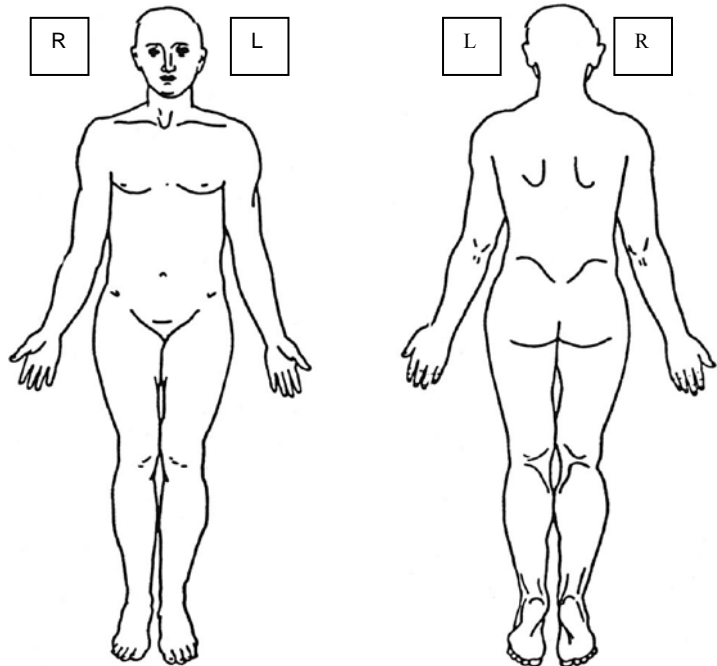
E.3 Please describe your pain or hurting. (Check all that apply.)

Check all that apply.

- | | | | |
|--|--------------------------------------|--|--|
| <input type="checkbox"/> a. Constant | <input type="checkbox"/> e. Burning | <input type="checkbox"/> i. Ache/Throb | <input type="checkbox"/> m. Tightness |
| <input type="checkbox"/> b. Intermittent | <input type="checkbox"/> f. Pinching | <input type="checkbox"/> j. Stabbing | <input type="checkbox"/> n. Stiffness |
| <input type="checkbox"/> c. Sharp | <input type="checkbox"/> g. Numbness | <input type="checkbox"/> k. Pulling | <input type="checkbox"/> o. Other: Please write in _____ |
| <input type="checkbox"/> d. Dull | <input type="checkbox"/> h. Tingling | <input type="checkbox"/> l. Cramping | |

E.4 Pain/Hurting Location

Please mark with an X the area(s) of your body where you have pain or hurting.



E.5 Pain/Hurting Effect on Sleep (Check one box.)

During the past 2 days, has pain made it hard for you to sleep?

No Yes Don't know

E.6 Pain/Hurting Effect on Activities (Check one box.)

During the past 2 days, have you limited your activities because of pain?

No Yes Don't know

II. Patient Information (cont.)

F.1 Basic Mobility

Do you have difficulty with getting around (mobility), either walking or in a wheelchair?

- Yes → If "yes," please answer the rest of the questions on this page.
 No → If "no," please skip to the next page.

How much DIFFICULTY do you currently have... (If you have not done an activity recently, how much difficulty do you think you would have if you tried?)	Unable	A Lot	A Little	None
a. Moving from sitting at the side of the bed to lying down on your back?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Moving up in bed (e.g., reposition self)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Standing for at least one minute?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Sitting down in an armless straight chair (e.g., dining room chair)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Standing up from an armless straight chair (e.g., dining room chair)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Getting into and out of a car/taxi (sedan)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Cleaning up spills on the floor (e.g., with a rag or mop)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Walking around one floor of your home, taking into consideration thresholds, doors, furniture, and a variety of floor coverings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Going up and down a flight of stairs inside, using a handrail?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Bending over from a standing position to pick up a piece of clothing from the floor without holding onto anything?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Walking several blocks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Walking up and down steep unpaved inclines (e.g., steep gravel driveway)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Taking a 1-mile brisk walk, without stopping to rest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Carrying something in both arms while climbing a flight of stairs (e.g., laundry basket)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How much HELP from another person do you currently need... (If you have not done an activity recently, how much help do you think you would need if you tried?)	Unable	A Lot	A Little	None
o. Moving to and from a bed to a chair (including a wheelchair)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Moving to and from a toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Stepping into and out of a shower?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F.2 Do you also use a wheelchair to get around?

- Yes → If "yes," please answer the rest of the questions on this page.
 No → If "no," please skip to the next page.

Without help from another person, when you are using your wheelchair, how much DIFFICULTY do you currently have... (If you have not done an activity recently, how much help do you think you would need if you tried?)	Unable	A Lot	A Little	None
a. Moving around within one room, including making turns in a wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Reaching for a high object, using a wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Opening a door away from a wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Opening a door toward a wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Transferring between a wheelchair and other seating surfaces, such as a chair or bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Propelling/driving a wheelchair several blocks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

II. Patient Information (cont.)

F.3 Everyday Activities

Do you have difficulty with engaging in everyday activities?

- Yes → If "yes," please answer the rest of the questions on this page.
 No → If "no," please skip to the next page.

How much HELP do you currently need... (If you have not done an activity recently, how much help do you think you would need if you tried?)	Unable	A Lot	A Little	None
a. Taking care of your personal grooming such as brushing teeth, combing hair, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Bathing yourself (including washing, rinsing, drying the body)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much DIFFICULTY do you currently have... (If you have not done an activity recently, how much difficulty do you think you would have if you tried?)	Unable	A Lot	A Little	None
c. Inserting a key in a lock and turning it to unlock the door?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Picking up thin, flat objects from a table (e.g., coins, post card, envelope)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Putting on and taking off a shirt or blouse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Putting on and taking off socks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Opening small containers like aspirin or vitamins (regular screw tops)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Picking up a gallon carton of milk with one hand and setting it on the table?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Removing stiff plastic packaging using hands and scissors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Tying shoes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Replacing or tightening small parts using only your hands (e.g., screws)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Unscrewing the lid off a previously unopened jar without using devices?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Washing indoor windows?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Pounding a nail in straight with a hammer to hang a picture?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Lifting 25 pounds from the ground to a table?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Cutting your toenails?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

II. Patient Information (cont.)

F.4 Life Skills

Do you have difficulty with communicating, remembering, organizing, or planning in your daily life?

Yes → If "yes," please answer the rest of the questions on this page.

No → If "no," please go to the next page.

How much DIFFICULTY do you currently have... (If you have not done an activity recently, how much difficulty do you think you would have if you tried?)	Unable	A Lot	A Little	None
a. Understanding instructions involving several steps (e.g., how to prepare a meal or following directions)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Following/understanding a 10- to 15-minute speech or presentation (e.g., lesson at a place of worship, guest lecture).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Answering yes/no questions about basic needs (e.g., "Do you need to use the restroom?" "Are you in pain?")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Making yourself understood to other people during ordinary conversations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Telling someone important information about yourself in case of emergency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Explaining how to do something involving several steps to another person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Reading and following complex instructions (e.g., directions to operate a new appliance or for a new medication)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Telling others your basic needs (e.g., need to use the restroom, have a drink of water or request help)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Planning for and keeping appointments that are not part of your weekly routine (e.g., a therapy or doctor appointment, or a social gathering with friends and family)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Reading simple material (e.g., a menu or the TV or radio guide)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Filling out a long form (e.g., insurance form or an application for services)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Writing down a short message or note?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Getting to know new people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Remembering where things were placed or put away (e.g., keys)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Remembering personal information (e.g., medical history, important events)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Keeping track of time (e.g., using a clock)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Putting together a shopping list of 10 to 15 items?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Remembering a list of 4 or 5 errands without writing it down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Taking care of complicated tasks like managing a checking account or getting appliances fixed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

II. Patient Information (cont.)

G. Participation

G.1 Taking into account any help or services that are unavailable to you, how much are you currently limited in...

	Not At All	A Little	Somewhat	Very Much	Extremely Limited
a. Keeping your home clean and fixed up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Providing personal care to yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Getting groceries or other things for your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G.2 How much are you currently limited in...

	Not At All	A Little	Somewhat	Very Much	Extremely Limited	Don't Do This/Not Applicable
a. Doing recreational or leisure activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Going to movies, plays, concerts, sporting events, museums, or similar activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G.3 Think about how you currently socialize with others, like going out or visiting with family and friends. Which of the following best describes you? (Check one box.)

- I do not have any difficulty doing things socially.
- I maintain my usual pattern of social activities, despite some difficulties.
- I am somewhat restricted in the amount or type of social activities I do.
- I am very restricted in the amount or type of social activities I do.
- I do not see family or friends, and I only see those who provide care to me.

H. Additional Questions

H.1 Living Situation – What is your current living situation? (Check all that apply.)

- | | | |
|------------------------------|--|--|
| Check all that apply. | <input type="checkbox"/> a. I live with my spouse/significant other | <input type="checkbox"/> d. I live with paid help |
| | <input type="checkbox"/> b. I live with adult children/other family or friends | <input type="checkbox"/> e. I live alone |
| | <input type="checkbox"/> c. I live with other people (not family or friends) | <input type="checkbox"/> f. I live in a nursing home |

H.2 History of Falls

	Yes	No	Don't know
a. Have you had two or more falls in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you had any fall with injury in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

H.3 Feeling Sad?

During the past 2 weeks, how often would you say, "I feel sad?"

- Never Rarely Sometimes Often Always Don't know

H.4 Confidence

Thinking about all the activities you like to do, how much confidence do you feel today about your overall ability in doing them?

- None Some A lot Complete Don't know

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

III. Provider Information

Providers, please complete by the end of your therapy session.

A. Primary Reason for Therapy

Please indicate the primary body function(s), body structure(s), and activity & participation reason(s) for which you are treating this patient using the categories below. **Check all primary reasons for therapy that apply.**

A.1 Body Functions (Check at least one)

- a. Global Mental Functions (consciousness, orientation, intellectual function, energy & drive, sleep, temperament, personality)
- b. Specific Mental Functions (attention, memory, psychomotor, emotional, perceptual, higher level cognition, sequencing of complex tasks, calculation, mental functions of language)
- c. Seeing & Related Functions
- d. Hearing
- e. Vestibular Functions
- f. Proprioceptive & Touch Functions
- g. Other Sensory Functions (taste, smell)
- h. Pain
- i. Voice & Speech Functions (articulation, speech, fluency & rhythm, alternative vocalization)
- j. Functions of the Cardiovascular System
- k. Functions of the Immunological & Hematological Systems
- l. Functions of the Respiratory System
- m. Functions of the Digestive System
- n. Functions Related to Metabolism & Endocrine System
- o. Urinary Functions
- p. Genital & Reproductive Functions
- q. Functions of the Joints & Bones
- r. Muscle Functions (muscle power, tone, endurance)
- s. Movement Functions (motor reflexes, involuntary movements, control of movements, gait patterns, neuromuscular functions)
- t. Functions of the Skin
- u. Functions of the Hair & Nails

A.2 Body Structures (Check at least one)

Structures Related to Movement

- a. General/No Specific Body Location
- b. Head
- c. Cervical Spine
- d. Thoracic Spine
- e. Lumbar Spine
- f. Pelvic Girdle

L: Left Side; R: Right Side

L R

- g. Hip
- h. Thigh
- i. Knee
- j. Calf
- k. Foot/Ankle
- l. Toes
- m. Shoulder
- n. Arm
- o. Elbow
- p. Wrist
- q. Hand
- r. Fingers

Structures Involved in Voice & Speech

- s. Nose
- t. Mouth
- u. Tongue
- v. Pharynx
- w. Larynx

Other Structures

- x. Eye & Related Structures
- y. Ear & Related Structures
- z. Structures of the Central Nervous System
- aa. Structures of the Peripheral Nervous System
- bb. Structures of the Cardiovascular, Immunological, & Respiratory Systems
- cc. Structures Related to the Digestive, Metabolic, & Endocrine Systems
- dd. Structures Related to the Genitourinary & Reproductive Systems
- ee. Skin & Related Structures

A.3 Activities and Participation (Check at least one)

- a. Purposeful Sensory Experiences (watching, listening)
- b. Basic Learning (copying, rehearsing, learning to read, write, acquiring skills)
- c. Applying Knowledge (focusing attention, thinking, reading, writing, calculating, solving problems, making decisions)
- d. General Tasks & Demands (simple and multiple tasks, carrying out daily routine, handling stress)
- e. Communication: Receiving (spoken, nonverbal, sign language, written)
- f. Communication: Producing (speaking, nonverbal, sign language, writing)
- g. Conversation & Use of Communication Devices (conversation, discussion, using devices and techniques)
- h. Changing & Maintaining Body Position
- i. Carrying, Moving, & Handling Objects
- j. Walking & Moving
- k. Moving Around Using Transportation
- l. Self Care (washing oneself, toileting, dressing, eating, drinking)
- m. Acquisition of Necessities (a place to live, goods and services)
- n. Household Tasks (preparing meals, doing housework)
- o. Caring for Household Objects & Assisting Others
- p. General Interpersonal Interactions
- q. Particular Interpersonal Interactions (relating with strangers, formal and informal relationships, family and intimate relationships)
- r. Education
- s. Work & Employment
- t. Economic Life
- u. Community, Social, & Civic Life

A.4 Why is the patient receiving therapy services covered by Medicare Part B?

Check all that apply.

- a. Continuation of therapy services provided under Medicare Part A
- b. Change in physical functional status
- c. Change in cognitive status (incl. emergence from coma, persistent vegetative state, etc.)
- d. Change in medical status
- e. Change in or loss of caregiver
- f. Other (specify) _____

III. Provider Information (cont.)

Providers, please complete by the end of your therapy session.

B. Primary and Secondary Medical Diagnoses

Based on available medical information, please indicate the patient's primary (1ary) and secondary (2ary) medical conditions. The primary diagnosis should be related to the reason for therapy. **Please check all that apply.**

B.1 Musculoskeletal

- 1ary 2ary
- a. Pain Syndrome (fibromyalgia, polymyalgia, etc.)
 - b. Pain, Not Pain Syndrome
 - c. Osteoarthritis
 - d. Rheumatoid Arthritis
 - e. TMJ Disorder
 - f. Fracture
 - g. Sprain/Strain
 - h. Osteoporosis
 - i. Herniated Disc
 - j. Spinal Stenosis
 - k. Scoliosis
 - l. Torticollis
 - m. Contusion
 - n. Joint Replacement
 - o. Amputation
 - p. Bursitis
 - q. Tendonitis
 - r. Internal Derangement of Joint
 - s. Tendon Rupture
 - t. Nerve Entrapment
 - u. Contracture
 - v. Other _____

B.2 Circulatory

- 1ary 2ary
- a. TIA
 - b. Stroke
 - c. Atrial Fibrillation & Other Dysrhythmia (bradycardia, tachycardia)
 - d. Coronary Artery Disease (angina, myocardial infarction)
 - e. Deep Vein Thrombosis (DVT)
 - f. Heart Failure (including pulmonary edema)
 - g. Hypertension
 - h. Peripheral Vascular Disease/Peripheral Arterial Disease
 - i. Other _____

B.3 Lymphatic System

- 1ary 2ary
- a. Lymphedema
 - b. Other _____

B.4 Pulmonary/Respiratory System

- 1ary 2ary
- a. Asthma
 - b. Bronchitis
 - c. Pneumonia
 - d. Chronic Obstructive Pulmonary Disease (COPD)
 - e. Cystic Fibrosis
 - f. Other _____

B.5 Integumentary System

- 1ary 2ary
- a. Skin Ulcer/Wound
 - b. Burn
 - c. Other _____

B.6 Genitourinary System

- 1ary 2ary
- a. End Stage Renal Disease (ESRD)
 - b. Incontinence
 - c. Pelvic Pain
 - d. Other _____

B.7 Mental Health

- 1ary 2ary
- a. Anxiety Disorder
 - b. Depression
 - c. Bipolar Disease
 - d. Attention Disorder
 - e. Schizophrenia
 - f. Alzheimer's Disease
 - g. Other _____

B.8 Cancer/Other Neoplasms

- 1ary 2ary
- a. Please Specify _____

B.9 Metabolic System

- 1ary 2ary
- a. Diabetes Mellitus
 - b. Obesity
 - c. Other _____

B.10 Generalized Weakness

- 1ary 2ary
- a. Generalized Weakness

B.11 Infectious Diseases

- 1ary 2ary
- a. Please Specify _____

B.12 HIV

- 1ary 2ary
- a. HIV

B.13 Gastrointestinal Disorders

- 1ary 2ary
- a. Please Specify _____

B.14 Immune Disorders

- 1ary 2ary
- a. Immune Disorders

B.15 Anemias/Other Hematological Disorders

- 1ary 2ary
- a. Anemia
 - b. Other _____

B.16 Congenital Abnormalities

- 1ary 2ary
- a. Musculoskeletal Congenital Deformities/Anomalies
 - b. Neurological Congenital/Developmental Anomalies
 - c. Other _____

B.17 Neurological Conditions

- 1ary 2ary
- a. Specific Diseases of Central Nervous System (CNS)
 - b. Cranial Neuralgia
 - c. Cranial Nerve Injury
 - d. Seizure Disorder
 - e. Paralysis
 - f. Peripheral Nervous System Disorder (including neuropathy)
 - g. Complex Regional Syndrome
 - h. Vertigo
 - i. Multiple Sclerosis
 - j. Parkinson's
 - k. Huntington's Disease
 - l. Head Injury
 - m. Traumatic Brain Injury
 - n. Non-Traumatic Brain Injury
 - o. Encephalopathy
 - p. Retinopathy
 - q. Guillain-Barré Syndrome
 - r. Other _____

B.18 Cognition/Judgement

- 1ary 2ary
- a. Executive Function Disorder
 - b. Memory Impairment
 - c. Pragmatics Disorder
 - d. Dementia
 - e. Other _____

B.19 Communication, Voice, or Speech Disorder

- 1ary 2ary
- a. Aphasia
 - b. Apraxia of Speech
 - c. Reading or Writing Dysfunction
 - d. Voice Disorder (Dysphonia)
 - e. Speech Disorder
 - f. Cognitive-Communication Disorder
 - g. Other _____

B.20 Swallowing Disorder

- 1ary 2ary
- a. Dysphagia

B.21 Sensory Disorders/Gait or Balance Disorder

- 1ary 2ary
- a. Hearing Impairment
 - b. Vision Impairment
 - c. Gait or Balance Disorder
 - d. Other _____

B.22 Other Condition

- 1ary 2ary
- a. Please Specify _____

III. Provider Information (cont.)

C. Supplemental Conditions/Impairments

	Yes	No	Don't Know	If "Yes," complete...
C.1a Does the patient have any vision impairments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C.1b on page 11
C.2a Does the patient have any hearing impairments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C.2b on page 11
C.3a Does the patient have any signs or symptoms of a possible swallowing disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C.3b on page 11
C.4a Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C.4b & C.4c on page 12
C.5a Does the patient have any signs or symptoms of a possible communication impairment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C.5b–C.5d on page 12
C.6a Does this patient have one or more unhealed pressure ulcers at stage 2 or higher or unstageable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C.6b on page 13
C.7a Does the patient have any impairments with bladder or bowel management (e.g., use of a device or incontinence)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C.7b–C.7d on page 13

If you answered "No" or "Don't Know" to all of items C.1a–C.7a above, you are done with this assessment instrument and may skip all remaining items.

C.1 Vision

Answer **only** if you answered "Yes" to C.1a (Does the patient have any vision impairments?)

- C.1b Describe the patient's ability to see in adequate light (with glasses or other visual appliances)
- Adequate:** Sees fine detail, including regular print in newspapers/books
 - Mild to Moderately Impaired:** Can identify objects; may see large print
 - Severely Impaired:** No vision or object identification questionable

C.2 Hearing

Answer **only** if you answered "Yes" to C.2a (Does the patient have any hearing impairments?)

- C.2b Describe the patient's ability to hear (with hearing aid or hearing appliance, if normally used)
- Adequate:** Hears normal conversation and TV without difficulty
 - Mild to Moderately Impaired:** Difficulty hearing in some environments or speaker may need to increase volume or speak distinctly
 - Severely Impaired:** Absence of useful hearing

C.3 Swallowing

Answer **only** if you answered "Yes" to C.3a (Does the patient have any signs or symptoms of a possible swallowing disorder?)

- C.3b What signs and symptoms of a swallowing disorder does the patient have?
- Check all that apply.**
- 1. History of dysphagia/aspiration pneumonia
 - 2. Complaints of difficulty or pain with swallowing
 - 3. Coughing or choking during meals or when swallowing medications
 - 4. Holding food in mouth/cheeks or residual food in mouth after meals
 - 5. Loss of liquids/solids from mouth when eating or drinking
 - 6. NPO: intake not by mouth
 - 7. Other (specify) _____

III. Provider Information (cont.)

C.4 Cognitive Status

Answer **only** if you answered "Yes" to C.4a (Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?)

C.4b Please indicate all of the following that the patient is able to recall:

Check all that apply.

- 1. Current season
- 2. Location of own room (nursing home only)
- 3. Staff names and faces
- 4. That s/he is in a hospital, nursing home, clinic, office, or home
- 5. None of the above

C.4c Please describe the patient's problems with memory, attention, problem solving, planning, organizing, or judgment.

- Mildly impaired:** Demonstrates some difficulty with one or more of these cognitive abilities.
- Moderately impaired:** Demonstrates marked difficulty with one or more of these cognitive abilities.
- Severely impaired:** Demonstrates extreme difficulty with one or more of these cognitive abilities.

C.5 Communication

Answer **only** if you answered "Yes" to C.5a (Does the patient have any signs or symptoms of a possible communication impairment?)

C.5b Please describe the patient's problems with communication.

- Mildly impaired:** Demonstrates some difficulty with comprehension and/or expression but is able to functionally communicate most of the time.
- Moderately impaired:** Demonstrates marked difficulty with comprehension and/or expression that noticeably interferes with functional communication.
- Severely impaired:** Demonstrates extreme difficulty with comprehension and/or expression with little-to-no functional communication.

C.5c Please describe the patient's ability to understanding verbal content (excluding language barriers).

- Understands:** Clear comprehension without cues or repetitions.
- Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- Rarely/Never Understands.**

C.5d Please describe the patient's ability to express ideas and wants.

- Expresses complex messages **without difficulty** and with speech that is clear and easy to understand.
- Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear.
- Frequently** exhibits difficulty with expressing needs and ideas.
- Rarely/Never** expresses self or speech is very difficult to understand.

III. Provider Information (cont.)

C.6 Pressure Ulcers		
Answer only if you answered "Yes" to C.6a (Does this patient have one or more unhealed pressure ulcers at stage 2 or higher, or unstageable?)		
C.6b Do these pressure ulcers interfere with your therapy treatments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
C.7 Incontinence		
Answer only if you answered "Yes" to C.7a (Does the patient have any impairments with bladder or bowel management [e.g., use of a device or incontinence]?)		
C.7b Does the incontinence interfere with your therapy treatments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
C.7c&d Please Indicate the frequency of the patient's bladder and bowel incontinence.	C.7c Bladder	C.7d Bowel
	<input type="checkbox"/>	<input type="checkbox"/> Stress Incontinence Only
	<input type="checkbox"/>	<input type="checkbox"/> Incontinent Less Than Daily
	<input type="checkbox"/>	<input type="checkbox"/> Incontinent Daily
	<input type="checkbox"/>	<input type="checkbox"/> Always Incontinent
	<input type="checkbox"/>	<input type="checkbox"/> No Urine/Bowel Output
<input type="checkbox"/>	<input type="checkbox"/> Not Applicable	

2D Provider Barcode

III. Provider Information (cont.)

D. Supplemental Swallowing, Cognition, & Communication Function

Are you treating or evaluating this patient for any of the following reasons?

	Yes	No	If "Yes," complete...
D.1a Signs or symptoms of a possible swallowing disorder?	<input type="checkbox"/>	<input type="checkbox"/>	D.2 on page 14
D.1b Difficulty with communicating in daily life?	<input type="checkbox"/>	<input type="checkbox"/>	D.3–D.6 on pages 14 & 15
D.1c Difficulty with remembering, organizing, or attending in daily life?	<input type="checkbox"/>	<input type="checkbox"/>	D.7–D. 9 on page 16

If you answered "No" to all of items D.1a–D.1c above, you are done with this assessment instrument and may skip all remaining items.

D.2 Swallowing Function

Answer **only** if you answered "Yes" to D.1a (Signs or symptoms of a possible swallowing disorder?)

For safety and maximal nutritional intake, the patient requires:	D.2a Diet Modification	D.2b Level of Cueing or Assistance
Liquid Diet Modification: Thickened liquids (e.g., consistency of syrup, honey, or pudding)	<input type="checkbox"/> Both Liquids & Solids	<input type="checkbox"/> Maximal
Solid Diet Modification: Cooked until soft; chopped, ground, mashed; or pureed	<input type="checkbox"/> Either Liquids or Solids	<input type="checkbox"/> Minimal
Maximal Cueing: Multiple cues that are obvious to nonclinicians, including any combination of auditory, visual, pictorial, tactile, or written cues	<input type="checkbox"/> None	<input type="checkbox"/> None
Minimal Cueing: Subtle and only one type of cueing		

D.3–D.6 Communication Function

Answer **only** if you answered "Yes" to D.1b (Difficulty with communicating in daily life?)

In Questions D.3 through D.6, please use the following definitions for the frequency with which the patient can perform the indicated activity and for level of assistance:

Frequency Performing Activity	Never:	Unable
	Rarely:	Less than 20% of the time
	Sometimes:	Between 20% and 49% of the time
	Usually or Always:	At least 50% of the time
Level of Assistance	Without Assistance:	Patient performance without cueing, external guidance, assistive device, or other compensatory augmentative intervention
	With Assistance:	Patient performance with cueing, external guidance, assistive device, or other compensatory augmentative intervention

D.3 Language Comprehension

The patient comprehends:

Basic Information: Simple directions; simple yes/no questions; simple words or phrases

Complex Information: Complex sentences/directions/messages; conversations about routine daily activities

	Basic Information		Complex Information	
	D.3a Without Assistance	D.3b With Assistance	D.3c Without Assistance	D.3d With Assistance
Never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually or Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

III. Provider Information (cont.)

D.4 Language Expression

The patient conveys:

Basic Information: Simple directions; simple yes/no questions; simple words or phrases

Complex Information: Complex sentences/directions/messages; conversations about routine daily activities

	Basic Information		Complex Information	
	D.4a Without Assistance	D.4b With Assistance	D.4c Without Assistance	D.4d With Assistance
Never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually or Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D.5 Motor Speech Production

The patient's speech is:

Intelligible in Short Utterances: Short consonant-vowel combinations; automatic words; simple words or predictable phrases

Intelligible in Conversation: Long utterances; low predictability sentences; communication in vocational, avocational, and social activities

	Intelligible in Short Utterances		Intelligible in Conversation	
	D.5a Without Assistance	D.5b With Assistance	D.5c Without Assistance	D.5d With Assistance
Never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually or Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D.6 Voice

The patient's voice is functional in the following types of activities:

Low Vocal Demand: Speaking softly; speaking in quiet environments; talking for short periods of time

High Vocal Demand: Speaking loudly; speaking in noisy environments; talking for extended periods of time

	Low Vocal Demand		High Vocal Demand	
	D.6a Without Assistance	D.6b With Assistance	D.6c Without Assistance	D.6d With Assistance
Never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually or Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

III. Provider Information (cont.)

D.7–D.9 Cognitive Function

Answer **only** if you answered “Yes” to D.1c (Difficulty with remembering, organizing, or attending in daily life?)

In Questions D.7 through D.9, please use the following definitions for the frequency with which the patient can perform the indicated activity and for level of assistance:

Frequency Performing Activity	Never:	Unable
	Rarely:	Less than 20% of the time
	Sometimes:	Between 20% and 49% of the time
	Usually or Always:	At least 50% of the time
Level of Assistance	Without Assistance:	Patient performance without cueing, external guidance, assistive device, or other compensatory augmentative intervention
	With Assistance:	Patient performance with cueing, external guidance, assistive device, or other compensatory augmentative intervention

D.7 Problem Solving

The patient solves:

Simple Problems: Following schedules; requesting assistance; using a call bell; identifying basic wants/needs; preparing a simple cold meal

Complex problems: Working on a computer; managing personal, medical, and financial affairs; preparing a complex hot meal; grocery shopping; route finding and map reading

	Simple Problems		Complex Problems	
	D.7a Without Assistance	D.7b With Assistance	D.7c Without Assistance	D.7d With Assistance
Never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually or Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D.8 Memory

The patient recalls:

Basic Information: Personal information (e.g., family members, biographical information, physical location); schedules; names of familiar staff; location of therapy area

Complex Information: Complex and novel information (e.g., carry out multiple-step activities, follow a plan); anticipate future events (e.g., keeping appointments)

	Basic Information		Complex Information	
	D.8a Without Assistance	D.8b With Assistance	D.8c Without Assistance	D.8d With Assistance
Never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually or Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D.9 Attention

The patient maintains attention for:

Simple Activities: Following simple directions; reading environmental signs; eating a meal; completing personal hygiene; dressing

Complex Activities: Watching a news program; reading a book; planning and preparing a meal; managing one’s own medical, financial, and personal affairs

	Simple Activities		Complex Activities	
	D.9a Without Assistance	D.9b With Assistance	D.9c Without Assistance	D.9d With Assistance
Never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually or Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV. Other Useful Information

A. Is there other useful information about this patient that you want to add?

V. Feedback

A. Notes

Thank you for your participation in this important project. So that we may improve the form for future use, please comment on any areas of concern or things you would change about the form.