

# I. Administrative Information

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

**A.1 Current Date**      /  /    
M M / D D / Y Y Y Y

**Patient Information or ID Sticker**  
 Patient Name \_\_\_\_\_  
 Date of Birth    \_\_\_\_-\_\_\_\_-\_\_\_\_

**A.2 Patient's Medicare Health Insurance Claim Number**                                    

**A.3 Does the patient need someone to assist them to complete Section II - Patient Information, or answer for them?**  
 There are several items in Section II - Patient Information intended to be reported by the patient. However, some patients may need assistance completing the form.

- A **"recorder"** is someone who writes the answers provided by the patient who can respond reliably; even if the patient requires assistance understanding the content, or giving an answer. A recorder should not influence or answer for the patient.
- A **"proxy"** is someone who answers the questions on behalf of the patient. The proxy determines the content of the answer based upon their knowledge of the patient.

**A.3a 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 (proxy) or needs to have someone else complete the form for them (recorder). Please check all that apply.**

**A "recorder" should be used if:**

- 1. The patient cannot read English or Spanish.
- 2. The patient has difficulty reading, but can answer reliably verbally.
- 3. The patient cannot write their own responses on the form (e.g., upper limb impairment, vision impairment).
- 4. The patient has difficulty understanding instructions.

**8. The patient does not need any assistance and can complete the questionnaire him/herself.**

**A "proxy" should be used if:**

- 5. The patient cannot concentrate for 15 minutes.
- 6. The patient cannot give correct/accurate answers to questions about their health.
- 7. Another reason:  
\_\_\_\_\_

**If a patient meets any of the above conditions for a proxy, please choose a proxy from the following list in the order presented below:**

1. Family member or companion who came to the appointment with the patient
2. Treating therapist

**A.3b Who completed Section II - Patient Information?**

- Patient
- Recorder:**     Family Member     Companion Not Family     Office Staff     Therapist
- Proxy:**     Family Member     Companion Not Family     Therapist

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## **CARE C ADMISSION/INTAKE QUESTIONNAIRE**

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 0938-1096. The time required to complete this information collection is estimated to average 30 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.

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# II. Patient Information

|   |  |
|---|--|
| <b>A.1 Current Date</b><br>___/___/___<br>M M D D Y Y Y Y | <b>Patient Information or ID Sticker</b><br><br>Patient Name _____<br><br>Date of Birth ____-____-____ |
|---|--|

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

|                        |                     |                       |
|------------------------|---------------------|-----------------------|
| <b>B.1a First Name</b> | <b>B.1b Initial</b> | <b>B.1c Last Name</b> |
|------------------------|---------------------|-----------------------|

|   |   |
|---|---|
| <b>B.2 Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female | <b>B.3 Birth Date</b> ___/___/___<br>MM DD YYYY |
|---|---|

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

|                              |  |   |
|------------------------------|--|---|
| <b>Check all that apply.</b> | <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>B.5 Education</b> | <input type="checkbox"/> Less than high school diploma | <input type="checkbox"/> High school graduate/GED |
| (Check one box)      | <input type="checkbox"/> Some college - no degree      | <input type="checkbox"/> College degree or higher |

**C.1 Primary Condition**

**What are the main health problems for which you are receiving therapy? Check all that apply.**

|  |   |   |
|--|---|---|
| <b>Check all that apply.</b>                                       | <b>Problems of the muscles, ligaments, joints and/or bones</b>        |   |
|  | <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                                       |   |
|  | <b>Other problems:</b>  |   |
|  | <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)                        |   |

|  |
|--|
| <b>C.2 How long ago did the health problems for which you are being treated begin?</b>         |
| <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 |

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## CARE C ADMISSION/INTAKE QUESTIONNAIRE

### C.3 Surgical Status

a. Indicate the number of surgeries you have had in the past for the medical problem for which you are receiving therapy.

None (Skip to → C.4)       1       2       3       4 or more

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

Within the last week       Within the last 3 months  
 Within the last month       More than 3 months ago

## II. Patient Information (cont.)

### C.4 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.**

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

## II. Patient Information (cont.)

### D. Pain or Hurting

#### D.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"/> |

**If you are a proxy (family member, companion, or therapist) completing this questionnaire, please skip to → D.6.**

#### D.2 Pain or Hurting Severity (Check one box.)

Please rate your worst pain during the last 2 days from 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine.

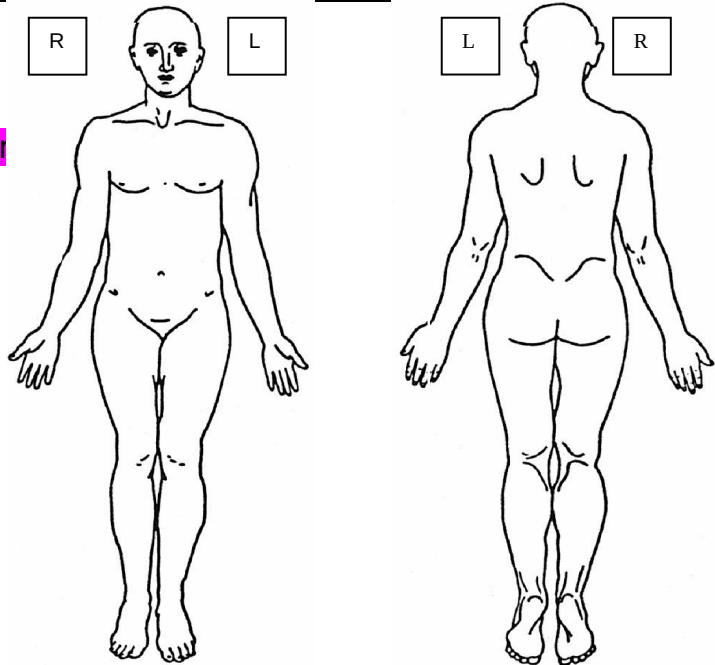
|                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <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               |                          |                          |                          |

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

|                              |  |                                      |  |  |
|------------------------------|--|--------------------------------------|--|--|
| <b>Check all that apply.</b> | <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   |  |

#### D.4 Pain/Hurting Location

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



#### D.4 Pain/Hurting Effect on Sleep (Check one box.)

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

#### D.5 Pain/Hurting Effect on Activities (Check one box.)

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

## CARE C ADMISSION/INTAKE QUESTIONNAIRE

No  Yes  Don't know

No  Yes  Don't know

**D.6 If you are a proxy (family member, companion, or therapist) please complete: Pain Observational Assessment. If patient could not be interviewed for pain assessment, check all indicators of pain or possible pain.**

**Check all that**

- D.6a Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
- D.6b Vocal complaints of pain** (e.g., "that hurts, ouch, stop")
- D.6c Facial expressions** (e.g., grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- D.6d Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- D.6e None** of these signs observed or documented

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## II. Patient Information (cont.)

### E.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 E.2.

| How much DIFFICULTY do you currently have...<br>(If you have not done an activity recently, how much difficulty do you think you would have if you tried?) | Unabl<br>e               | A Lot<br>of<br>Difficu<br>lty | A Little<br>Difficult<br>y | No<br>Difficu<br>lty     | Don't<br>Know            |
|--|--------------------------|-------------------------------|----------------------------|--------------------------|--------------------------|
| 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"/> | <input type="checkbox"/> |
| b. Moving up in bed (e.g., reposition self)?   | <input type="checkbox"/> | <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"/> | <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"/> | <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"/> | <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"/> | <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"/> | <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"/> | <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"/> | <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"/> | <input type="checkbox"/> |
| k. Reaching overhead while standing, as if to pull a light cord?   | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Walking several blocks?   | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Walking up and down steep unpaved inclines (e.g., steep gravel driveway)?   | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Taking a 1-mile brisk walk, without stopping to rest?   | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| o. 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"/> | <input type="checkbox"/> |

| How much HELP from another person do you currently need...<br>(If you have not done an activity recently, how much help do you think you would need if you tried?) | Unabl<br>e               | A Lot<br>of<br>Help<br>Need<br>ed | A Little<br>Help<br>Need<br>ed | No<br>Help<br>Need<br>ed | Don't<br>Know            |
|--|--------------------------|-----------------------------------|--------------------------------|--------------------------|--------------------------|
| p. Moving to and from a bed to a chair (including a wheelchair)?   | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>       | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Moving to and from a toilet?  | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>       | <input type="checkbox"/> | <input type="checkbox"/> |
| r. Stepping into and out of a shower?  | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>       | <input type="checkbox"/> | <input type="checkbox"/> |

### E.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?) | Unabl<br>e               | A Lot<br>of<br>Difficu<br>lty | A Little<br>Difficult<br>y | No<br>Difficu<br>lty     | Don't<br>Know            |
|---|--------------------------|-------------------------------|----------------------------|--------------------------|--------------------------|
| a. Moving around within one room, including making turns in a wheelchair?   | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |



### CARE C ADMISSION/INTAKE QUESTIONNAIRE

|  |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| b. Reaching for a high object, using a wheelchair?                                       | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| d. Opening a door toward a wheelchair?   | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| f. Propelling/driving a wheelchair several blocks?                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## II. Patient Information (cont.)

### E.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.

| <b>How much HELP do you currently need...</b><br>(If you have not done an activity recently, how much help do you think you would need if you tried?)             | <b>Unabl<br/>e</b>       | <b>A Lot<br/>of<br/>Help<br/>Neede<br/>d</b> | <b>A Little<br/>Help<br/>Needed</b> | <b>No<br/>Help<br/>Neede<br/>d</b> | <b>Don't<br/>Know</b>    |
|---|--------------------------|--|-------------------------------------|------------------------------------|--------------------------|
| 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"/>           | <input type="checkbox"/> |
| b. Bathing yourself (including washing, rinsing, drying the body)?  | <input type="checkbox"/> | <input type="checkbox"/>                     | <input type="checkbox"/>            | <input type="checkbox"/>           | <input type="checkbox"/> |
| <b>How much DIFFICULTY do you currently have...</b><br>(If you have not done an activity recently, how much difficulty do you think you would have if you tried?) | <b>Unabl<br/>e</b>       | <b>A Lot of<br/>Difficult<br/>y</b>          | <b>A Little<br/>Difficult<br/>y</b> | <b>No<br/>Difficult<br/>y</b>      | <b>Don't<br/>Know</b>    |
| 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"/>           | <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"/>           | <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"/>           | <input type="checkbox"/> |
| f. Putting on and taking off socks?   | <input type="checkbox"/> | <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"/>           | <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"/>           | <input type="checkbox"/> |
| i. Removing stiff plastic packaging using hands and scissors?   | <input type="checkbox"/> | <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"/>           | <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"/>           | <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"/>           | <input type="checkbox"/> |
| m. Washing indoor windows?  | <input type="checkbox"/> | <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"/>           | <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"/>           | <input type="checkbox"/> |
| p. Cutting your toenails?   | <input type="checkbox"/> | <input type="checkbox"/>                     | <input type="checkbox"/>            | <input type="checkbox"/>           | <input type="checkbox"/> |

## II. Patient Information (cont.)

### E.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 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?)

|   | Unabl<br>e               | A Lot of<br>Difficult<br>y | A Little<br>Difficult<br>y | No<br>Difficult<br>y     | Don't<br>Know            |
|---|--------------------------|----------------------------|----------------------------|--------------------------|--------------------------|
| 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"/> | <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"/> | <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"/> | <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"/> | <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"/> | <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"/> | <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"/> | <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"/> | <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"/> | <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"/> | <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"/> | <input type="checkbox"/> |
| l. Writing down a short message or note?  | <input type="checkbox"/> | <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"/> | <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"/> | <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"/> | <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"/> | <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"/> | <input type="checkbox"/> |
| r. Remembering a list of 4 or 5 errands without   | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |

### CARE C ADMISSION/INTAKE QUESTIONNAIRE

|   |                          |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| writing it down?  |                          |                          |                          |                          |                          |
| 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"/> | <input type="checkbox"/> |

## II. Patient Information (cont.)

### F. Participation

**F.1 Even with help or services, tell us how much you are limited in...**

|   | Not At All Limited       | A Little Limited         | Somewhat Limited         | Very Much Limited        | Extremely Limited        | Don't Do This/Not Applicable |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------|
| a. Keeping your home clean and fixed up?            | <input type="checkbox"/> | <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"/> | <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"/> | <input type="checkbox"/>     |

**F.2 How much are you currently limited in...**

|   | Not At All Limited       | A Little Limited         | Somewhat Limited         | Very Much Limited        | Extremely Limited        | Don't Do This/Not Applicable |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------|
| a. 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"/>     |

**F.3 Think about how you currently get together or do things 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 with others socially.
- Even though it's hard, I keep doing things with people as usual.
- I no longer can do as much or the same kinds of things with others.
- I hardly ever do the types of things I use to do, or I hardly ever get together with others.
- I do not see family or friends, and I only see those who take care of me.

### G. Additional Questions

**G.1 Living Situation - What is your current living situation? (Check all that apply.)**

|                              |  |   |
|------------------------------|--|---|
| <b>Check all that apply.</b> | <input type="checkbox"/> a. I live with my spouse/significant other            | <input type="checkbox"/> d. I live with paid help (e.g., personal care) |
|                              | <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                    |

### G.2 History of Falls

|  | Yes                      | No                       | Don't know               |
|--|--------------------------|--------------------------|--------------------------|
| a. Have you had two or more falls in the last 12 months?                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you had any fall that resulted in an injury in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### G.3 Feeling Sad?

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

- Never     Rarely     Sometimes     Often     Always     Don't know

### G.4 Confidence

Thinking about all the activities you like to do, how much confidence do you feel today about your overall

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**CARE C ADMISSION/INTAKE QUESTIONNAIRE**

ability in doing them?

None

Some

A lot

Complete

Don't know

**THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!**

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# III. Provider Information

|  |  |  |
|--|--|--|
| <p><b>A. Names and National Provider Identification Codes (NPI) for therapists billing separately</b></p> <p>Please enter the name and NPI of the therapist completing this assessment. Each licensed therapist who treats the patient must complete their own separate "Provider Information" sections.</p> | <p><b>Patient Information or ID Sticker</b></p> <p>Patient Name _____</p> <p>Date of Birth _____</p> |  |
| <b>Therapist Name</b>  | <b>Therapist Type</b>  | <b>National Provider Identification Code (NPI)</b> |
| A.1a _____   | A.2a PT <input type="radio"/> OT <input type="radio"/> SLP <input type="radio"/>                     | A.3a  _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _              |

**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. Also, mark ALL secondary diagnoses that the patient has.

|  |  |
|--|--|
| <p><b>B.1 Musculoskeletal</b></p> <p><u>1ary</u> <u>2ary</u></p> <p><input type="radio"/> <input type="radio"/> a. Pain Syndrome (fibromyalgia, polymyalgia, etc.)</p> <p><input type="radio"/> <input type="radio"/> b. Pain, Not Pain Syndrome</p> <p><input type="radio"/> <input type="radio"/> c. Osteoarthritis</p> <p><input type="radio"/> <input type="radio"/> d. Rheumatoid Arthritis</p> <p><input type="radio"/> <input type="radio"/> e. TMJ Disorder</p> <p><input type="radio"/> <input type="radio"/> f. Fracture</p> <p><input type="radio"/> <input type="radio"/> g. Sprain/Strain</p> <p><input type="radio"/> <input type="radio"/> h. Osteoporosis</p> <p><input type="radio"/> <input type="radio"/> i. Herniated Disc</p> <p><input type="radio"/> <input type="radio"/> j. Spinal Stenosis</p> <p><input type="radio"/> <input type="radio"/> k. Scoliosis</p> <p><input type="radio"/> <input type="radio"/> l. Torticollis</p> <p><input type="radio"/> <input type="radio"/> m. Contusion</p> <p><input type="radio"/> <input type="radio"/> n. Joint Replacement</p> <p><input type="radio"/> <input type="radio"/> o. Amputation</p> <p><input type="radio"/> <input type="radio"/> p. Bursitis</p> <p><input type="radio"/> <input type="radio"/> q. Tendonitis</p> <p><input type="radio"/> <input type="radio"/> r. Internal Derangement of Joint</p> <p><input type="radio"/> <input type="radio"/> s. Tendon Rupture</p> <p><input type="radio"/> <input type="radio"/> t. Nerve Entrapment</p> <p><input type="radio"/> <input type="radio"/> u. Contracture</p> <p><input type="radio"/> <input type="radio"/> v. Other _____</p> <p><b>B.2 Circulatory</b></p> <p><u>1ary</u> <u>2ary</u></p> <p><input type="radio"/> <input type="radio"/> a. TIA</p> <p><input type="radio"/> <input type="radio"/> b. Stroke</p> <p><input type="radio"/> <input type="radio"/> c. Atrial Fibrillation &amp; Other Dysrhythmia (bradycardia, tachycardia)</p> <p><input type="radio"/> <input type="radio"/> d. Coronary Artery Disease (angina, myocardial infarction)</p> <p><input type="radio"/> <input type="radio"/> e. Deep Vein Thrombosis (DVT)</p> <p><input type="radio"/> <input type="radio"/> f. Heart Failure (including pulmonary edema)</p> <p><input type="radio"/> <input type="radio"/> g. Hypertension</p> <p><input type="radio"/> <input type="radio"/> h. Peripheral Vascular Disease/Peripheral Arterial Disease</p> | <p><b>B.3 Lymphatic System</b></p> <p><u>1ary</u> <u>2ary</u></p> <p><input type="radio"/> <input type="radio"/> a. Lymphedema</p> <p><input type="radio"/> <input type="radio"/> b. Other _____</p> <p><b>B.4 Pulmonary/Respiratory System</b></p> <p><u>1ary</u> <u>2ary</u></p> <p><input type="radio"/> <input type="radio"/> a. Asthma</p> <p><input type="radio"/> <input type="radio"/> b. Bronchitis</p> <p><input type="radio"/> <input type="radio"/> c. Pneumonia</p> <p><input type="radio"/> <input type="radio"/> d. Chronic Obstructive Pulmonary Disease (COPD)</p> <p><input type="radio"/> <input type="radio"/> e. Cystic Fibrosis</p> <p><input type="radio"/> <input type="radio"/> f. Other _____</p> <p><b>B.5 Integumentary System</b></p> <p><u>1ary</u> <u>2ary</u></p> <p><input type="radio"/> <input type="radio"/> a. Skin Ulcer/Wound</p> <p><input type="radio"/> <input type="radio"/> b. Burn</p> <p><input type="radio"/> <input type="radio"/> c. Other _____</p> <p><b>B.6 Genitourinary System</b></p> <p><u>1ary</u> <u>2ary</u></p> <p><input type="radio"/> <input type="radio"/> a. End Stage Renal Disease (ESRD)</p> <p><input type="radio"/> <input type="radio"/> b. Incontinence</p> <p><input type="radio"/> <input type="radio"/> c. Pelvic Pain</p> <p><input type="radio"/> <input type="radio"/> d. Other _____</p> <p><b>B.7 Mental Health</b></p> <p><u>1ary</u> <u>2ary</u></p> <p><input type="radio"/> <input type="radio"/> a. Anxiety Disorder</p> <p><input type="radio"/> <input type="radio"/> b. Depression</p> <p><input type="radio"/> <input type="radio"/> c. Bipolar Disease</p> <p><input type="radio"/> <input type="radio"/> d. Attention Disorder</p> <p><input type="radio"/> <input type="radio"/> e. Schizophrenia</p> <p><input type="radio"/> <input type="radio"/> f. Alzheimer's Disease</p> <p><input type="radio"/> <input type="radio"/> g. Other _____</p> <p><b>B.8 Cancer/Other Neoplasms</b></p> <p><u>1ary</u> <u>2ary</u></p> <p><input type="radio"/> <input type="radio"/> a. Please Specify _____</p> |
|--|--|

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|                       |                       |          |  |
|-----------------------|-----------------------|----------|--|
| <input type="radio"/> | <input type="radio"/> | i. Other |  |
|-----------------------|-----------------------|----------|--|

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### III. Provider Information (cont.)

**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/Judgment**

1ary 2ary

- a. Executive Function Disorder (difficulty with planning, initiating, monitoring, and evaluating goal direct behavior)
- b. Memory Impairment
- c. Pragmatics Disorder (difficulty with the appropriate use of language in social situations)
- 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.)

## Functional Status / Performance

### C. Mobility Devices and Aids Needed

**C.1 Indicate all mobility devices and aids being used at the time of this assessment.**

- Check all that apply.**
- a. Canes/crutch
  - b. Walker
  - c. Orthotics/prosthetic
  - d. Wheelchair/scooter full time
  - e. Wheelchair/scooter part time
  - f. Mechanical lift
  - g. Other (specify) \_\_\_\_\_
  - h. None apply

### D. Self Care

**Code the patient's performance using the 6-point scale below. Answer those questions for which you have the skills, knowledge, or training, to provide a response; otherwise, check code "N".**

**CODING:**

**Safety and Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

*If patient has an assistive device, score patient using this device.*

- 6. Independent** - Patient completes the activity by him/herself with no assistance from a helper.
- 5. Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
- 4. Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

- 3. Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 2. Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 1. Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the task.
- N. Activity Not Assessed** - The item was not assessed because: a) not clinically relevant for this patient or b) the therapist does not feel that this item can be coded based upon his/her skill, knowledge, or training.

| Patient's Performance         |                          |                          |                          |                          |                          | Activity Not Assessed Code |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------------------|
| 6 = Independent 1 = Dependent |                          |                          |                          |                          |                          |                            |
| 6                             | 5                        | 4                        | 3                        | 2                        | 1                        | N                          |
| <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"/> | <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"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   |

**D.1 Oral hygiene:** The ability to use suitable items to clean teeth. Dentures: The ability to remove and replace dentures from and to mouth, and manage equipment for soaking and rinsing.

**D.2 Wash upper body:** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.

**D.3 Upper body dressing:** The ability to put on and remove shirt. Includes buttoning if applicable.

**D.4 Lower body dressing:** The ability to dress and undress below the waist, including fasteners. Does not include footwear.

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## CARE C ADMISSION/INTAKE QUESTIONNAIRE

|   |                          |                          |                          |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>D.5 Putting on/taking off footwear:</b> The ability to put on and take off socks and shoes or other footwear that are appropriate for safe mobility. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

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# III. Provider Information (cont.)

## Functional Status / Performance (cont.)

### E. Functional Mobility

Code the patient's performance using the 6-point scale below. Answer those questions for which you have the skills, knowledge, or training, to provide a response; otherwise, check code "N".

**CODING:**

**Safety and Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

*If patient has an assistive device, score patient using this device.*

**6. Independent** - Patient completes the activity by him/herself with no assistance from a helper.

**5. Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.

**4. Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

**3. Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

**2. Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

**1. Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the task.

**N. Activity Not Assessed** - The item was not assessed because: a) not clinically relevant for this patient or b) the therapist does not feel that this item can be coded based upon his/her skill, knowledge, or training.

|   | Patient's Performance         |                          |                          |                          |                          |                          | Activity Not Assessed Code |
|---|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------------------|
|   | 6 = Independent 1 = Dependent |                          |                          |                          |                          |                          |                            |
|   | 6                             | 5                        | 4                        | 3                        | 2                        | 1                        | N                          |
| <b>E.1 Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.  | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   |
| <b>E.2 Roll left and right:</b> The ability to roll from lying on back to left and right side, and roll back to back.   | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   |
| <b>E.3 Lying to sitting on side of bed:</b> The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support. | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   |
| <b>E.4 Sit to stand:</b> The ability to safely come to a standing position from sitting in a chair or on the side of the bed.   | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   |
| <b>E.5 Chair/bed-to-chair transfer:</b> The ability to safely transfer to and from a chair (or wheelchair). The chairs are placed at right angles to each other.              | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   |
| <b>E.6 Picking up object while standing:</b> The ability to bend/stoop from a standing position to pick up small object such as a spoon from the floor.                       | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   |
| <b>E.7 Walk 50 feet with two turns:</b> The ability to walk 50 feet and make two turns without a rest break.  | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   |
| <b>E.8 Walking 10 feet on uneven surfaces:</b><br>The ability to walk 10 feet on uneven or  | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   |

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### CARE C ADMISSION/INTAKE QUESTIONNAIRE

|             |   |                          |                          |                          |                          |                          |                          |                          |
|-------------|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|             | sloping surfaces, such as grass or gravel without a rest break.   |                          |                          |                          |                          |                          |                          |                          |
| <b>E.9</b>  | <b>Four steps:</b> The ability to go up and down 4 steps with or without a rail without a rest break.                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>E.10</b> | <b>Twelve steps:</b> The ability to go up and down 12 steps with or without a rail without a rest break.                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>E.11</b> | <b>Wheel up and down ramp:</b> Once seated in wheelchair, goes up and down a ramp of less than 12 feet (4 meters) without a rest break. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

# III. Provider Information (cont.)

## Functional Status / Performance (cont.)

### E. Functional Mobility

Code the patient's performance using the 6-point scale below. Answer those questions for which you have the skills, knowledge, or training, to provide a response; otherwise, check code "N".

**CODING:**

**Safety and Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

*If patient has an assistive device, score patient using this device.*

**6. Independent** - Patient completes the activity by him/herself with no assistance from a helper.

**5. Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.

**4. Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

**3. Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

**2. Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

**1. Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the task.

**N. Activity Not Assessed** - The item was not assessed because: a) not clinically relevant for this patient or b) the therapist does not feel that this item can be coded based upon his/her skill, knowledge, or training.

**E.12 Select the longest distance the patient walks without a rest break, and code his/her level of independence (Level 1-6). Observe performance. If patient does not walk, select E.12d and check "N". (SELECT ONLY ONE.)**

|  | Patient's Performance<br>6 = Independent 1 = Dependent |                          |                          |                          |                          |                          | Activity Not Assessed Code<br>N |
|--|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------------|
|  | 6  | 5                        | 4                        | 3                        | 2                        | 1                        |                                 |
| <b>E.12a Walk 500 ft (1500m):</b> Once standing, can walk at least 500 feet (1500 meters) in corridor or similar space.          | <input type="checkbox"/>                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        |
| <b>E.12b Walk 150 ft (45 m):</b> Once standing, can walk at least 150 feet (45 meters) in corridor or similar space.             | <input type="checkbox"/>                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        |
| <b>E.12c Walk 50 ft (15 m):</b> Once standing, can walk at least 50 feet (15 meters) in corridor or similar space.               | <input type="checkbox"/>                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        |
| <b>E.12d Walk in room once standing:</b> Once standing, can walk at least 10 feet (3 meters) in room, corridor or similar space. | <input type="checkbox"/>                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        |

**E.13 Select the longest distance the patient wheels without a rest break, and code his/her level of independence (Level 1-6). Observe performance. If patient does not use wheelchair, select E.13d and check "N". (SELECT ONLY ONE.)**

|  | Patient's Performance<br>6 = Independent 1 = Dependent |                          |                          |                          |                          |                          | Activity Not Assessed Code<br>N |
|--|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------------|
|  | 6  | 5                        | 4                        | 3                        | 2                        | 1                        |                                 |
| <b>E.13a Wheel 500 ft (1500 m):</b> Once seated, can wheel at least 500 feet (1500 meters) in corridor or similar space. | <input type="checkbox"/>                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        |
| <b>E.13b Wheel 150 ft (45 m):</b> Once seated, can   | <input type="checkbox"/>                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        |

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|   |                          |                          |                          |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| wheel at least 150 feet (45 meters) in corridor or similar space.   |                          |                          |                          |                          |                          |                          |                          |
| <b>E.13c Wheel 50 ft (15 m):</b> Once seated, can wheel at least 50 feet (15 meters) in corridor or similar space.              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>E.13d Wheel in room once seated:</b> Once seated, can wheel at least 10 feet (3 meters) in room, corridor, or similar space. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

# III. Provider Information (cont.)

## Functional Status / Performance (cont.)

### F. Instrumental Activities of Daily Living (IADL)

Code the patient's performance using the 6-point scale below. Answer those questions for which you have the skills, knowledge, or training, to provide a response; otherwise, check code "N".

**CODING:**

**Safety and Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

*If patient has an assistive device, score patient using this device.*

**6. Independent** - Patient completes the activity by him/herself with no assistance from a helper.

**5. Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.

**4. Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

**3. Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

**2. Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

**1. Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the task.

**N. Activity Not Assessed** - The item was not assessed because: a) not clinically relevant for this patient or b) the therapist does not feel that this item can be coded based upon his/her skill, knowledge, or training.

| Patient's Performance<br>6 = Independent 1 =<br>Dependent |   |   |   |   |   | Activity Not<br>Assessed<br>Code |
|---|---|---|---|---|---|----------------------------------|
| 6   | 5 | 4 | 3 | 2 | 1 | N                                |

**F.1 Medication management-oral medications:** The ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

|                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

**F.2 Make light meal:** The ability to plan and prepare all aspects of a light meal such as a sandwich and cold drink.

|                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

**F.3 Wipe down surface & clean the cloth:** The ability to use a damp cloth to wipe down surface such as table top or bench to remove small amounts of liquid or crumbs. Includes ability to clean cloth of debris in patient's customary manner.

|                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|



# III. Provider Information (cont.)

## G. Conditions/Impairments

|  | Yes                        | No                       | Not Assessed             | If "Yes," complete...     |
|--|----------------------------|--------------------------|--------------------------|---------------------------|
| <b>G.1</b> Does the patient have any <b>vision impairments</b> (cannot see fine detail, such as regular print in newspapers/books, with glasses or other visual appliances if normally used)?  | <input type="checkbox"/> * | <input type="checkbox"/> | <input type="checkbox"/> | G.1a-G.1b on page 16      |
| <b>G.2</b> Does the patient have any <b>hearing impairments</b> (has difficulty hearing conversation and TV at normal listening levels, with hearing aid or hearing appliance if normally used)?   | <input type="checkbox"/> * | <input type="checkbox"/> | <input type="checkbox"/> | G.2a-G.2b on page 16      |
| <b>G.3-4</b> Does the patient have any <b>signs or symptoms of a possible swallowing disorder</b> (G.3b) or does the patient require modified liquid/food modification?  | <input type="checkbox"/> * | <input type="checkbox"/> | <input type="checkbox"/> | G.3a-G.4c on page 16      |
| <b>G.5-8</b> Does the patient have any difficulty with <b>memory</b> (e.g., retain relevant functional information), <b>attention</b> (e.g., ability to stay focused on task), <b>problem solving/ planning, organizing or judgment</b> (refer to G.5a-G.8e)?  | <input type="checkbox"/> * | <input type="checkbox"/> | <input type="checkbox"/> | G.5a-G.8e on pages 17-18  |
| <b>G.9-13</b> Does the patient have any signs or symptoms of a <b>possible communication problem</b> , such as difficulty with oral or written language comprehension (e.g., needs repetition/gestures, has difficulty with reading comprehension) and/or oral or written expression (e.g., motor speech disorder, deficits in spoken language, writing deficits) of complex messages (excluding language barriers)? | <input type="checkbox"/> * | <input type="checkbox"/> | <input type="checkbox"/> | G.9a-G.13e on pages 19-21 |
| <b>G.14</b> Does this patient have one or more <b>unhealed pressure ulcers</b> at stage 2 or higher or unstageable?  | <input type="checkbox"/> * | <input type="checkbox"/> | <input type="checkbox"/> | G.14a-G.14b on page 21    |
| <b>G.15</b> Does the patient have any <b>impairments with bladder or bowel management</b> (e.g., use of a device or incontinence)?   | <input type="checkbox"/> * | <input type="checkbox"/> | <input type="checkbox"/> | G.15a-G.15d on page 21    |

- If you answered "Yes" to any items above (G.1-G.15), complete the more specific items G1a.-\* G15d.  
If you cannot answer the more specific question(s) G1a.-G15d. based on your skills, knowledge or training, then leave the item(s) blank and skip to → page 22 H. Primary Reason for Therapy.
- If you answered "No" or "Not Assessed" to ALL of items G.1-G.15 above, skip to → page 22 H. Primary Reason for Therapy.

### DEFINITIONS

**Possible swallowing disorder:**

**One or more of the following:** History of dysphagia/aspiration pneumonia, NPO intake not by mouth, complaints of difficulty or pain with swallowing, coughing or choking during meals (i.e. while eating or drinking) or when swallowing medications, wet vocal quality/and throat clearing or coughing after meals, holding food in mouth/cheeks or residual food in mouth/cheeks after meals, loss of liquids/solids from mouth when eating or drinking.

**Difficulty with memory, attention, problem solving, planning, organizing or judgment:**

**One or more of the following:** Memory (e.g., retain relevant functional information, retain multiple steps), attention (e.g., ability to stay focused on task), problem solving/planning, organizing or judgment (e.g., able to understand consequences of actions, safety awareness, follow sequences, plan and execute multiple steps for functional task, keep appointments).

**Difficulty communicating:**

**One or more of the following:** Motor speech disorder (e.g., slurred speech; speaking too slow or too

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fast; or too soft or too loud), deficits in spoken language expression (trouble with naming, grammar, expressing needs or ideas). deficits in comprehension (e.g., needs repetition, gesture, rephrasing, simplification to follow directions or understand), deficits in written expression (e.g., unable to write due to language rather than motor impairment), reading comprehension (e.g., unable to decode words or comprehend sentences or paragraphs), alaryngeal communication, or uses augmentative-alternative communication device.

**Language barrier:**

The patient does not speak the language in which treatment is conducted.

# III. Provider Information (cont.)

## G.1a Vision

Answer **only** if you answered “Yes” to G.1 “Does the patient have any vision impairments?” and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

**G.1b Describe the patient’s ability to see in adequate light** (with glasses or other visual appliances, if normally used)

- Mild to Moderately Impaired:** Can identify objects; may see large print
- Severely Impaired:** No vision or object identification questionable

## G.2a Hearing

Answer **only** if you answered “Yes” to G.2 “Does the patient have any hearing impairments?” and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

**G.2b Describe the patient’s ability to hear normal conversation and TV at normal listening levels** (with hearing aid or appliance, if normally used).

- 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

## G.3a Swallowing

Answer **only** if you answered “Yes” to G.3 “Signs or symptoms of a possible swallowing disorder?” and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

**G.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. Wet vocal quality and/or throat clearing
- 5. Holding food in mouth/cheeks or residual food in mouth after meals
- 6. Loss of liquids/solids from mouth when eating or drinking
- 7. NPO: intake not by mouth
- 8. Other (specify) \_\_\_\_\_

## G.4a Swallowing Function

Answer **only** if you answered “Yes” to G.4 “Signs or symptoms of a possible swallowing disorder?” and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

**For safety and maximal nutritional intake, the patient requires:**

**Liquid Diet Modification:** Thickened liquids (e.g., consistency of syrup, nectar, honey, or pudding)

**Solid Diet Modification:** Cooked until soft; chopped, ground, mashed; or pureed

| G.4b<br>Diet Modification                         | G.4c<br>Level of Cueing or Assistance |
|---|---------------------------------------|
| <input type="checkbox"/> Both Liquids & Solids    | <input type="checkbox"/> Maximal      |
| <input type="checkbox"/> Either Liquids or Solids | <input type="checkbox"/> Moderate     |
| <input type="checkbox"/> None                     | <input type="checkbox"/> Minimal      |
|   | <input type="checkbox"/> None         |

**Level of Cueing or Assistance:**

**Maximal Cueing:** Multiple cues that are obvious to non-clinicians, including any combination of auditory, visual, pictorial, tactile, or written cues.

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**Moderate Cueing:** Combination of cueing types, some of which may be obvious to non-clinicians, including any combination of auditory, visual, pictorial, tactile, or written cues.

**Minimal Cueing:** Subtle and only one type of cueing.

**None:** No cueing provided.

# III. Provider Information (cont.)

## G.5a Cognitive Status

Answer **only** if you answered "Yes" to G.5 "Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?" and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

**G.5a 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

**G.5b Please describe the patient's problems with:**

- Memory
- Attention
- Problem Solving
- Planning
- Organizing
- 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.

## G.6a Problem Solving

Answer **only** if you answered "Yes" to G.6 "Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?" and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

**The patient solves:**

**Simple Problems:** Following basic 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              |                            |
|-----------------|-------------------------------|----------------------------|-------------------------------|----------------------------|
|                 | G.6b<br>Without<br>Assistance | G.6c<br>With<br>Assistance | G.6d<br>Without<br>Assistance | G.6e<br>With<br>Assistance |
| Never or 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         | <input type="checkbox"/>      | <input type="checkbox"/>   | <input type="checkbox"/>      | <input type="checkbox"/>   |
| Always          | <input type="checkbox"/>      | <input type="checkbox"/>   | <input type="checkbox"/>      | <input type="checkbox"/>   |

**Level of Assistance:**

**Without Assistance:** \_\_\_\_\_ Patient performance **without** cueing, assistive device, or other compensatory augmentative intervention

**With Assistance:** Patient performance **with** cueing, assistive device, or other compensatory augmentative intervention

**Frequency of problem solving:**

**Never or Rarely:** \_\_\_\_\_ Less than 20% of the time

**Sometimes:** Between 20% and 49% of the time

**Usually:** Between 50% and 79% of the time

**Always:** At least 80% of the time

# III. Provider Information (cont.)

## G.7a Memory

Answer **only** if you answered “Yes” to G.7 “Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?” and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

**The patient recalls:**

**Basic Information:** Personal information (e.g., family members, biographical information, physical location); basic 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      |                          |
|-----------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                 | G.7b Without Assistance  | G.7c With Assistance     | G.7d Without Assistance  | G.7e With Assistance     |
| Never or 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         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Always          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Level of Assistance:**

**Without Assistance:** \_\_\_\_\_ Patient performance **without** cueing, assistive device, or other compensatory augmentative intervention

**With Assistance:** \_\_\_\_\_ Patient performance **with** cueing, assistive device, or other compensatory augmentative intervention

**Frequency of memory:**

**Never or Rarely:** \_\_\_\_\_ Less than 20% of the time

**Sometimes:** \_\_\_\_\_ Between 20% and 49% of the time

**Usually:** \_\_\_\_\_ Between 50% and 79% of the time

**Always:** \_\_\_\_\_ At least 80% of the time

## G.8a Attention

Answer **only** if you answered “Yes” to G.8 “Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?” and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

**The patient maintains attention for:**

**Simple Activities:** Following simple directions; reading environmental signs or short newspaper/magazine/book passage; 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       |                          |
|-----------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                 | G.8b Without Assistance  | G.8c With Assistance     | G.8d Without Assistance  | G.8e With Assistance     |
| Never or 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         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Always          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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### **Level of Assistance:**

**Without Assistance:** \_\_\_\_\_ Patient performance **without** cueing, assistive device, or other compensatory augmentative intervention

**With Assistance:** Patient performance **with** cueing, assistive device, or other compensatory augmentative intervention

### **Frequency of maintaining attention:**

**Never or Rarely:** \_\_\_\_\_ Less than 20% of the time

**Sometimes:** \_\_\_\_\_ Between 20% and 49% of the time

**Usually:** \_\_\_\_\_ Between 50% and 79% of the time

**Always:** \_\_\_\_\_ At least 80% of the time

# III. Provider Information (cont.)

## G.9a Communication

Answer **only** if you answered “Yes” to G.9 “Does the patient have any signs or symptoms of a possible communication problem?” and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

**G.9b 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/repetition at times to understand.
- Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues/repetition to understand.
- Rarely/Never Understands.**

**G.9c 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.

## G.10a Spoken Language Comprehension

Answer **only** if you answered “Yes” to G.10 “Does the patient have any signs or symptoms of a possible communication problem?” and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

| The patient comprehends:<br><b>Basic Information:</b> Simple 1-step directions; simple yes/no questions; simple words or short phrases<br><b>Complex Information:</b> Complex sentences, 2-3 step directions, 2-3 part messages; conversations about routine daily activities and a variety of topics | Basic Information        |                          | Complex Information      |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
|   | G.10b Without Assistance | G.10c With Assistance    | G.10d Without Assistance | G.10e With Assistance    |
| Never or 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   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Always  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### Level of Assistance:

**Without Assistance:** Patient performance **without** cueing (verbal/written/repetition), assistive device, or other compensatory augmentative intervention

**With Assistance:** Patient performance **with** cueing (verbal/written/repetition), assistive device, or other compensatory augmentative intervention

### Frequency of spoken language comprehension:

**Never or Rarely:** \_\_\_\_\_ Less than 20% of the time

**Sometimes:** Between 20% and 49% of the time

**Usually:** Between 50% and 79% of the time

**Always:** At least 80% of the time



# III. Provider Information (cont.)

## G.11a Spoken Language Expression

Answer **only** if you answered “Yes” to G.11 “Does the patient have any signs or symptoms of a possible communication problem?”, and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

| The patient conveys:  |                 | Basic Information              |                             | Complex Information            |                             |
|---|-----------------|--------------------------------|-----------------------------|--------------------------------|-----------------------------|
|   |                 | G.11b<br>Without<br>Assistance | G.11c<br>With<br>Assistance | G.11d<br>Without<br>Assistance | G.11e<br>With<br>Assistance |
| <b>Basic Information:</b> Basic information regarding wants/needs or daily routines; using 1-2 words or short phrases<br><br><b>Complex Information:</b> Thoughts/ideas using sentences; in conversations about routine daily activities or a variety of topics | Never or 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         | <input type="checkbox"/>       | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
|   | Always          | <input type="checkbox"/>       | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |

### Level of Assistance:

**Without Assistance:** \_\_\_\_\_ Patient performance **without** cueing (verbal/written/repetition), assistive device, or other compensatory augmentative intervention

**With Assistance:** \_\_\_\_\_ Patient performance **with** cueing (verbal/written/repetition), assistive device, or other compensatory augmentative intervention

### Frequency of spoken language expression:

**Never or Rarely:** \_\_\_\_\_ Less than 20% of the time

**Sometimes:** \_\_\_\_\_ Between 20% and 49% of the time

**Usually:** \_\_\_\_\_ Between 50% and 79% of the time

**Always:** \_\_\_\_\_ At least 80% of the time

## G.12a Motor Speech Production

Answer **only** if you answered “Yes” to G.12 “Does the patient have any signs or symptoms of a possible communication problem?” and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

| The patient’s speech is:   |                 | Intelligible in Short Utterances |                             | Intelligible in Longer Utterances |                             |
|--|-----------------|----------------------------------|-----------------------------|-----------------------------------|-----------------------------|
|  |                 | G.12b<br>Without<br>Assistance   | G.12c<br>With<br>Assistance | G.12d<br>Without<br>Assistance    | G.12e<br>With<br>Assistance |
| <b>Intelligible in Short Utterances:</b> Spontaneous production of automatic words, predictable single words, or short phrases in conversation<br><br><b>Intelligible in Longer Utterances:</b> Spontaneous production of multisyllabic words in sentences | Never or 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         | <input type="checkbox"/>         | <input type="checkbox"/>    | <input type="checkbox"/>          | <input type="checkbox"/>    |
|  | Always          | <input type="checkbox"/>         | <input type="checkbox"/>    | <input type="checkbox"/>          | <input type="checkbox"/>    |

### Level of Assistance:

**Without Assistance:** \_\_\_\_\_ Patient performance **without** cueing/repetition, assistive device, or other compensatory augmentative intervention

**With Assistance:** \_\_\_\_\_ Patient performance **with** cueing/repetition, assistive device, or other compensatory augmentative intervention

### Frequency of motor speech production:

**Never or Rarely:** \_\_\_\_\_ Less than 20% of the time

**Sometimes:** \_\_\_\_\_ Between 20% and 49% of the time

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**Usually:** Between 50% and 79% of the time

**Always:** At least 80% of the time

### III. Provider Information (cont.)

**G.13a Functional Voice**

Answer **only** if you answered “Yes” to G.13 “Does the patient have any signs or symptoms of a possible communication problem?” and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

| The patient’s voice is functional in the following types of activities:  | Low Vocal Demand         |                          | High Vocal Demand        |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
|  | G.13b Without Assistance | G.13c With Assistance    | G.13d Without Assistance | G.13e With Assistance    |
| <b>Low Vocal Demand:</b> Speaking softly; speaking in quiet environments; talking for short periods of time      | Never or Rarely          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | Sometimes                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | Usually                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>High Vocal Demand:</b> Speaking loudly; speaking in noisy environments; talking for extended periods of time. | Always                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Level of Assistance:**

**Without Assistance:** Patient performance **without** cueing, assistive device, or other compensatory augmentative intervention

**With Assistance:** Patient performance **with** cueing, assistive device, or other compensatory augmentative intervention

**Frequency of functional voice:**

**Never or Rarely:** \_\_\_\_\_ Less than 20% of the time

**Sometimes:** Between 20% and 49% of the time

**Usually:** Between 50% and 79% of the time

**Always:** At least 80% of the time

**G.14a Pressure Ulcers**

Answer **only** if you answered “Yes” to G.14 “Does this patient have one or more unhealed pressure ulcers at stage 2 or higher, or unstageable?” and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

**G.14b Do these pressure ulcers interfere with your therapy treatments?**  Yes  No

**G.15a Incontinence**

Answer **only** if you answered “Yes” to G.15 “Does the patient have any impairments with bladder or bowel management (e.g., use of a device or incontinence)?” and if you have the skills, knowledge, or training, to provide a response; otherwise, leave this section blank.

**G.15b Does the incontinence interfere with your therapy treatments?**  Yes  No

| G.15c&d<br>frequency of the patient’s bladder and bowel incontinence. (Check one box in each column.) | Please check in both     |                          |                             |
|---|--------------------------|--------------------------|-----------------------------|
|   | G.15c Bladder            | G.15d Bowel              |                             |
| <input type="checkbox"/>  | <input type="checkbox"/> |                          | Stress Incontinence Only    |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | Incontinent Less Than Daily |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | Incontinent Daily           |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | Always Incontinent          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | No Urine/Bowel Output       |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | Not Applicable              |

2D Provider Barcode

# CARE C ADMISSION/INTAKE QUESTIONNAIRE

2D Provider  
Barcode

# III. Provider Information (cont.)

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

## H. 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. **Mark all primary reasons for therapy that apply.**

| <b>H.1</b> Body Functions (Check at least one)   | <b>H.2</b> Body Structures (Check at least one)  | <b>H.3</b> Activities and Participation (Check at least one)  |
|--|--|---|
| <ul style="list-style-type: none"> <li><input type="radio"/> a. Global Mental Functions (consciousness, orientation, intellectual function, energy &amp; drive, sleep, temperament, personality)</li> <li><input type="radio"/> b. Specific Mental Functions (attention, memory, psychomotor, emotional, perceptual, higher level cognition, sequencing of complex tasks, calculation, mental functions of language)</li> <li><input type="radio"/> c. Seeing &amp; Related Functions</li> <li><input type="radio"/> d. Hearing</li> <li><input type="radio"/> e. Vestibular Functions</li> <li><input type="radio"/> f. Proprioceptive &amp; Touch Functions</li> <li><input type="radio"/> g. Other Sensory Functions (taste, smell)</li> <li><input type="radio"/> h. Pain</li> <li><input type="radio"/> i. Voice &amp; Speech Functions (articulation, speech, fluency &amp; rhythm, alternative vocalization)</li> <li><input type="radio"/> j. Functions of the Cardiovascular System</li> <li><input type="radio"/> k. Functions of the Immunological &amp; Hematological Systems</li> <li><input type="radio"/> l. Functions of the Respiratory System</li> <li><input type="radio"/> m. Functions of the Digestive System</li> <li><input type="radio"/> n. Functions Related to Metabolism &amp; Endocrine System</li> <li><input type="radio"/> o. Urinary Functions</li> <li><input type="radio"/> p. Genital &amp; Reproductive Functions</li> <li><input type="radio"/> q. Functions of the Joints &amp; Bones</li> <li><input type="radio"/> r. Muscle Functions (muscle power, tone, endurance)</li> <li><input type="radio"/> s. Movement Functions (motor reflexes, involuntary movements, control of movements, gait patterns, neuromuscular functions)</li> <li><input type="radio"/> t. Functions of the Skin</li> <li><input type="radio"/> u. Functions of the Hair &amp; Nails</li> </ul> | <p>Structures Related to Movement</p> <ul style="list-style-type: none"> <li><input type="radio"/> a. General/No Specific Body Location</li> <li><input type="radio"/> b. Head</li> <li><input type="radio"/> c. Cervical Spine</li> <li><input type="radio"/> d. Thoracic Spine</li> <li><input type="radio"/> e. Lumbar Spine</li> <li><input type="radio"/> f. Pelvic Girdle</li> </ul> <p><b>L: Left Side; R: Right Side</b></p> <p><b>L R</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> g. Hip</li> <li><input type="radio"/> h. Thigh</li> <li><input type="radio"/> i. Knee</li> <li><input type="radio"/> j. Calf</li> <li><input type="radio"/> k. Foot/Ankle</li> <li><input type="radio"/> l. Toes</li> <li><input type="radio"/> m. Shoulder</li> <li><input type="radio"/> n. Arm</li> <li><input type="radio"/> o. Elbow</li> <li><input type="radio"/> p. Wrist</li> <li><input type="radio"/> q. Hand</li> <li><input type="radio"/> r. Fingers</li> </ul> <p>Structures Involved in Voice, Speech, &amp; Swallowing</p> <ul style="list-style-type: none"> <li><input type="radio"/> s. Nose</li> <li><input type="radio"/> t. Mouth</li> <li><input type="radio"/> u. Tongue</li> <li><input type="radio"/> v. Pharynx</li> <li><input type="radio"/> w. Larynx</li> </ul> <p>Other Structures</p> <ul style="list-style-type: none"> <li><input type="radio"/> x. Eye &amp; Related Structures</li> <li><input type="radio"/> y. Ear &amp; Related Structures</li> <li><input type="radio"/> z. Structures of the Central Nervous System</li> <li><input type="radio"/> aa. Structures of the Peripheral Nervous System</li> <li><input type="radio"/> bb. Structures of the Cardiovascular, Immunological, &amp; Respiratory Systems</li> <li><input type="radio"/> cc. Structures Related to the Digestive, Metabolic, &amp; Endocrine Systems</li> <li><input type="radio"/> dd. Structures Related to the Genitourinary &amp; Reproductive Systems</li> <li><input type="radio"/> ee. Skin &amp; Related Structures</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> a. Purposeful Sensory Experiences (watching, listening)</li> <li><input type="radio"/> b. Basic Learning (copying, rehearsing, learning to read, write, acquiring skills)</li> <li><input type="radio"/> c. Applying Knowledge (focusing attention, thinking, reading, writing, calculating, solving problems, making decisions)</li> <li><input type="radio"/> d. General Tasks &amp; Demands (simple and multiple tasks, carrying out daily routine, handling stress)</li> <li><input type="radio"/> e. Communication: Reception (spoken, nonverbal, sign language, written)</li> <li><input type="radio"/> f. Communication: Expression (speaking, nonverbal, sign language, writing)</li> <li><input type="radio"/> g. Conversation &amp; Use of Communication Devices (conversation, discussion, using devices and techniques)</li> <li><input type="radio"/> h. Changing &amp; Maintaining Body Position</li> <li><input type="radio"/> i. Carrying, Moving, &amp; Handling Objects</li> <li><input type="radio"/> j. Walking &amp; Moving</li> <li><input type="radio"/> k. Moving Around Using Transportation</li> <li><input type="radio"/> l. Self Care (washing oneself, toileting, dressing, eating, drinking)</li> <li><input type="radio"/> m. Acquisition of Necessities (a place to live, goods and services)</li> <li><input type="radio"/> n. Household Tasks (preparing meals, doing housework)</li> <li><input type="radio"/> o. Caring for Household Objects &amp; Assisting Others</li> <li><input type="radio"/> p. General Interpersonal Interactions</li> <li><input type="radio"/> q. Particular Interpersonal Interactions (relating with strangers, formal and informal relationships, family and intimate relationships)</li> <li><input type="radio"/> r. Education</li> <li><input type="radio"/> s. Work &amp; Employment</li> <li><input type="radio"/> t. Economic Life</li> <li><input type="radio"/> u. Community, Social, &amp; Civic Life</li> </ul> |

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

## CARE C ADMISSION/INTAKE QUESTIONNAIRE

|                             |   |
|-----------------------------|---|
| <b>Check all that apply</b> | <ul style="list-style-type: none"><li><input type="checkbox"/> a. Continuation of therapy services provided under Medicare Part A</li><li><input type="checkbox"/> b. Change in physical functional status</li><li><input type="checkbox"/> c. Change in cognitive status (incl. emergence from coma, persistent vegetative state, etc.)</li><li><input type="checkbox"/> d. Change in medical status</li><li><input type="checkbox"/> e. Change in availability or loss of caregiver</li><li><input type="checkbox"/> f. Other (specify) _____</li></ul> |
|-----------------------------|---|

2D Provider  
Barcode

## IV. Other Useful Information

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

## V. Feedback

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.