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 patent has difficulty understanding instructions.

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:
_____

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

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

FOR OFFICE USE ONLY

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II. Patient Information

A.1 Current Date |__|__| / |__|__| / |__|__|__|__|
M M D D Y Y Y Y

Patient Information or ID Sticker

Patient Name _____

Date of Birth _____-_____-_____

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

B.1a First Name	**B.1b Initial**	**B.1c Last Name**

B.2 Gender ☐ Male ☐ Female

B.3 Birth Date |__|__| / |__|__| / |__|__|__|__|
MM DD YYYY

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

Check all that apply.

☐ a. American Indian or Alaska Native
☐ b. Asian
☐ c. Black or African American
☐ d. Hispanic or Latino
☐ e. Native Hawaiian or Pacific Islander
☐ f. White
☐ g. Unknown

B.5 Education (Check one box) ☐ Less than high school diploma ☐ High school graduate/GED ☐ Some college – no degree ☐ College degree or higher

C.1 Primary Condition

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

Check all that apply.

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

☐ a. General
☐ b. Head and/or neck
☐ c. Back and/or pelvis
☐ d. Ribs and/or collarbone
☐ e. Hip
☐ f. Knee, leg, and/or foot
☐ g. Shoulder
☐ h. Elbow
☐ i. Wrist, hand, and/or fingers

Other problems:

☐ j. General weakness
☐ k. Problem with walking or balance
☐ l. Problem of the heart and/or blood vessels
☐ m. Problem of the lungs and/or breathing
☐ n. Problem of the nervous system
☐ o. Problems with eyes, inner ear, or ears
☐ p. Wound and/or skin problem
☐ q. Mental health condition
☐ r. Cancer
☐ s. Communication, voice, or speech disorder
☐ t. Swallowing disorder
☐ u. Other condition(s)

C.2 How long ago did the health problems for which you are being treated begin?

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

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

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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.

Check all that apply.

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

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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
	☐	☐	☐

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.

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
No Pain					Moderate Pain					Worst Pain

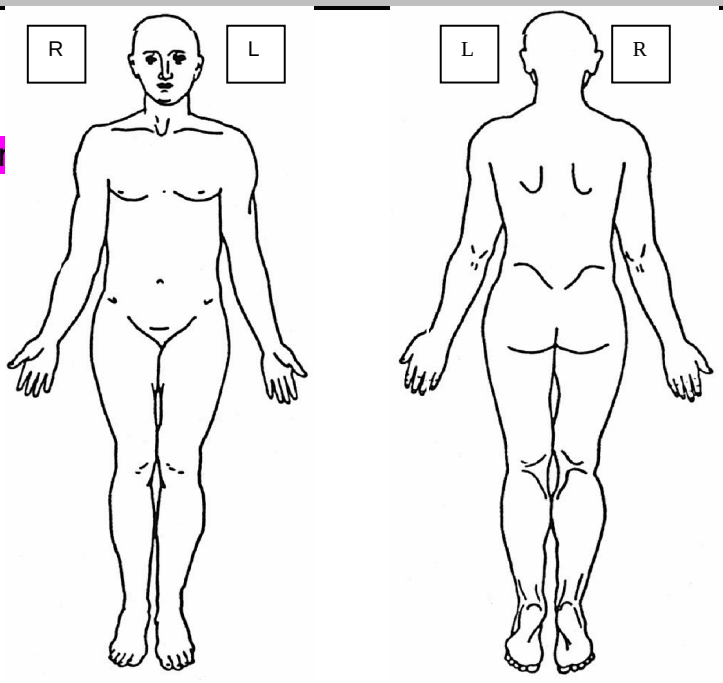
D.3 Please describe your pain or hurting. (Check all that apply.)

Check all that apply.

☐ a. Constant	☐ e. Burning	☐ i. Ache/Throb	☐ m. Tightness
☐ b. Intermittent	☐ f. Pinching	☐ j. Stabbing	☐ n. Stiffness
☐ c. Sharp	☐ g. Numbness	☐ k. Pulling	☐ o. Other: Please write in _____
☐ d. Dull	☐ h. Tingling	☐ l. Cramping	

D.4 Pain/Hurting Location

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



D.4 Pain/Hurting Effect on Sleep (Check one box.)	D.5 Pain/Hurting Effect on Activities (Check one box.)
During the past 2 days, has pain made it hard for you to sleep?	During the past 2 days, have you limited your activities because of pain?

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☐ 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 apply.

- ☐ **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, winces, 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

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… (If you have not done an activity recently, how much difficulty do you think you would have if you tried?)	**Unable**	**A Lot of Difficulty**	**A Little Difficulty**	**No Difficulty**	**Don't Know**
a. Moving from sitting at the side of the bed to lying down on your back?	☐	☐	☐	☐	☐
b. Moving up in bed (e.g., reposition self)?	☐	☐	☐	☐	☐
c. Standing for at least one minute?	☐	☐	☐	☐	☐
d. Sitting down in an armless straight chair (e.g., dining room chair)?	☐	☐	☐	☐	☐
e. Standing up from an armless straight chair (e.g., dining room chair)?	☐	☐	☐	☐	☐
f. Getting into and out of a car/taxi (sedan)?	☐	☐	☐	☐	☐
g. Cleaning up spills on the floor (e.g., with a rag or mop)?	☐	☐	☐	☐	☐
h. Walking around one floor of your home, taking into consideration thresholds, doors, furniture, and a variety of floor coverings?	☐	☐	☐	☐	☐
i. Going up and down a flight of stairs inside, using a handrail?	☐	☐	☐	☐	☐
j. Bending over from a standing position to pick up a piece of clothing from the floor without holding onto anything?	☐	☐	☐	☐	☐
k. Reaching overhead while standing, as if to pull a light cord?	☐	☐	☐	☐	☐
l. Walking several blocks?	☐	☐	☐	☐	☐
m. Walking up and down steep unpaved inclines (e.g., steep gravel driveway)?	☐	☐	☐	☐	☐
n. Taking a 1-mile brisk walk, without stopping to rest?	☐	☐	☐	☐	☐
o. Carrying something in both arms while climbing a flight of stairs (e.g., laundry basket)?	☐	☐	☐	☐	☐
How much HELP from another person do you currently need… (If you have not done an activity recently, how much help do you think you would need if you tried?)	**Unable**	**A Lot of Help Needed**	**A Little Help Needed**	**No Help Needed**	**Don't Know**
p. Moving to and from a bed to a chair (including a wheelchair)?	☐	☐	☐	☐	☐
q. Moving to and from a toilet?	☐	☐	☐	☐	☐
r. Stepping into and out of a shower?	☐	☐	☐	☐	☐

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?)	**Unable**	**A Lot of Difficulty**	**A Little Difficulty**	**No Difficulty**	**Don't Know**
a. Moving around within one room, including making turns in a wheelchair?	☐	☐	☐	☐	☐

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b. Reaching for a high object, using a wheelchair?	☐	☐	☐	☐	☐
c. Opening a door away from a wheelchair?	☐	☐	☐	☐	☐
d. Opening a door toward a wheelchair?	☐	☐	☐	☐	☐
e. Transferring between a wheelchair and other seating surfaces, such as a chair or bed?	☐	☐	☐	☐	☐
f. Propelling/driving a wheelchair several blocks?	☐	☐	☐	☐	☐

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.

How much HELP do you currently need… (If you have not done an activity recently, how much help do you think you would need if you tried?)	**Unable**	**A Lot of Help Needed**	**A Little Help Needed**	**No Help Needed**	**Don't Know**
a. Taking care of your personal grooming such as brushing teeth, combing hair, etc.?	☐	☐	☐	☐	☐
b. Bathing yourself (including washing, rinsing, drying the body)?	☐	☐	☐	☐	☐
How much DIFFICULTY do you currently have… (If you have not done an activity recently, how much difficulty do you think you would have if you tried?)	**Unable**	**A Lot of Difficulty**	**A Little Difficulty**	**No Difficulty**	**Don't Know**
c. Inserting a key in a lock and turning it to unlock the door?	☐	☐	☐	☐	☐
d. Picking up thin, flat objects from a table (e.g., coins, post card, envelope)?	☐	☐	☐	☐	☐
e. Putting on and taking off a shirt or blouse?	☐	☐	☐	☐	☐
f. Putting on and taking off socks?	☐	☐	☐	☐	☐
g. Opening small containers like aspirin or vitamins (regular screw tops)?	☐	☐	☐	☐	☐
h. Picking up a gallon carton of milk with one hand and setting it on the table?	☐	☐	☐	☐	☐
i. Removing stiff plastic packaging using hands and scissors?	☐	☐	☐	☐	☐
j. Tying shoes?	☐	☐	☐	☐	☐
k. Replacing or tightening small parts using only your hands (e.g., screws)?	☐	☐	☐	☐	☐
l. Unscrewing the lid off a previously unopened jar without using devices?	☐	☐	☐	☐	☐
m. Washing indoor windows?	☐	☐	☐	☐	☐
n. Pounding a nail in straight with a hammer to hang a picture?	☐	☐	☐	☐	☐
o. Lifting 25 pounds from the ground to a table?	☐	☐	☐	☐	☐
p. Cutting your toenails?	☐	☐	☐	☐	☐

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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?)	**Unable**	**A Lot of Difficulty**	**A Little Difficulty**	**No Difficulty**	**Don't Know**
a. Understanding instructions involving several steps (e.g., how to prepare a meal or following directions)?	☐	☐	☐	☐	☐
b. Following/understanding a 10- to 15-minute speech or presentation (e.g., lesson at a place of worship, guest lecture).	☐	☐	☐	☐	☐
c. Answering yes/no questions about basic needs (e.g., "Do you need to use the restroom?" "Are you in pain?")	☐	☐	☐	☐	☐
d. Making yourself understood to other people during ordinary conversations?	☐	☐	☐	☐	☐
e. Telling someone important information about yourself in case of emergency?	☐	☐	☐	☐	☐
f. Explaining how to do something involving several steps to another person?	☐	☐	☐	☐	☐
g. Reading and following complex instructions (e.g., directions to operate a new appliance or for a new medication)?	☐	☐	☐	☐	☐
h. Telling others your basic needs (e.g., need to use the restroom, have a drink of water or request help)?	☐	☐	☐	☐	☐
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)?	☐	☐	☐	☐	☐
j. Reading simple material (e.g., a menu or the TV or radio guide)?	☐	☐	☐	☐	☐
k. Filling out a long form (e.g., insurance form or an application for services)?	☐	☐	☐	☐	☐
l. Writing down a short message or note?	☐	☐	☐	☐	☐
m. Getting to know new people?	☐	☐	☐	☐	☐
n. Remembering where things were placed or put away (e.g., keys)?	☐	☐	☐	☐	☐
o. Remembering personal information (e.g., medical history, important events)?	☐	☐	☐	☐	☐
p. Keeping track of time (e.g., using a clock)?	☐	☐	☐	☐	☐
q. Putting together a shopping list of 10 to 15 items?	☐	☐	☐	☐	☐
r. Remembering a list of 4 or 5 errands without	☐	☐	☐	☐	☐

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writing it down?					
s. Taking care of complicated tasks like managing a checking account or getting appliances fixed?	☐	☐	☐	☐	☐

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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?	☐	☐	☐	☐	☐	☐
b. Providing personal care to yourself?	☐	☐	☐	☐	☐	☐
c. Getting groceries or other things for your home?	☐	☐	☐	☐	☐	☐

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?	☐	☐	☐	☐	☐	☐

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.)

Check all that apply.

☐ a. I live with my spouse/significant other
☐ b. I live with adult children/other family or friends
☐ c. I live with other people (not family or friends)
☐ d. I live with paid help (e.g., personal care)
☐ e. I live alone
☐ 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?	☐	☐	☐
b. Have you had any fall that resulted in an injury in the last 12 months?	☐	☐	☐

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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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

A. Names and National Provider Identification Codes (NPI) for therapists billing separately

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.

Patient Information or ID Sticker

Patient Name _____

Date of Birth ____-____-_____

Therapist Name	Therapist Type	National Provider Identification Code (NPI)
A.1a _____	**A.2a PT** ○ **OT** ○ **SLP** ○	**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.

B.1 Musculoskeletal

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

B.2 Circulatory

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

B.3 Lymphatic System

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

B.4 Pulmonary/Respiratory System

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

B.5 Integumentary System

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

B.6 Genitourinary System

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

B.7 Mental Health

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

B.8 Cancer/Other Neoplasms

1ary	2ary		
○	○	a.	Please Specify _____

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O O i. Other _____	

III. Provider Information (cont.)

B.9 Metabolic System

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

B.10 Generalized Weakness

1ary 2ary
- O O a. Generalized Weakness

B.11 Infectious Diseases

1ary 2ary
- O O a. Please Specify

B.12 HIV

1ary 2ary
- O O a. HIV

B.13 Gastrointestinal Disorders

1ary 2ary
- O O a. Please Specify

B.14 Immune Disorders

1ary 2ary
- O O a. Immune Disorders

B.15 Anemias/Other Hematological Disorders

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

B.16 Congenital Abnormalities

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

B.17 Neurological Conditions

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

B.18 Cognition/Judgment

1ary 2ary
- O O a. Executive Function Disorder (difficulty with planning, initiating, monitoring, and evaluating goal direct behavior)
- O O b. Memory Impairment
- O O c. Pragmatics Disorder (difficulty with the appropriate use of language in social situations)
- O O d. Dementia
- O O e. Other _____

B.19 Communication, Voice, or Speech Disorder

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

B.20 Swallowing Disorder

1ary 2ary
- O O a. Dysphagia

B.21 Sensory Disorders/Gait or Balance Disorder

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

B.22 Other Condition

1ary 2ary
- O O a. Please Specify _____

2D Provider Barcode

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 6 = Independent 1 = Dependent						Activity Not Assessed Code
	6	5	4	3	2	1	N
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.	☐	☐	☐	☐	☐	☐	☐

2D Provider Barcode

D.5 Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that are appropriate for safe mobility.	☐	☐	☐	☐	☐	☐	☐

2D Provider Barcode

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 6 = Independent 1 = Dependent						Activity Not Assessed Code
		6	5	4	3	2	1	N
E.1	**Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.	☐	☐	☐	☐	☐	☐	☐
E.2	**Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.	☐	☐	☐	☐	☐	☐	☐
E.3	**Lying to sitting on side of bed:** 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.	☐	☐	☐	☐	☐	☐	☐
E.4	**Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.	☐	☐	☐	☐	☐	☐	☐
E.5	**Chair/bed-to-chair transfer:** The ability to safely transfer to and from a chair (or wheelchair). The chairs are placed at right angles to each other.	☐	☐	☐	☐	☐	☐	☐
E.6	**Picking up object while standing:** The ability to bend/stoop from a standing position to pick up small object such as a spoon from the floor.	☐	☐	☐	☐	☐	☐	☐
E.7	**Walk 50 feet with two turns:** The ability to walk 50 feet and make two turns without a rest break.	☐	☐	☐	☐	☐	☐	☐
E.8	**Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or	☐	☐	☐	☐	☐	☐	☐

	sloping surfaces, such as grass or gravel without a rest break.							
E.9	**Four steps:** The ability to go up and down 4 steps with or without a rail without a rest break.	☐	☐	☐	☐	☐	☐	☐
E.10	**Twelve steps:** The ability to go up and down 12 steps with or without a rail without a rest break.	☐	☐	☐	☐	☐	☐	☐
E.11	**Wheel up and down ramp:** Once seated in wheelchair, goes up and down a ramp of less than 12 feet (4 meters) without a rest break.	☐	☐	☐	☐	☐	☐	☐

2D Provider Barcode

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 6 = Independent 1 = Dependent						Activity Not Assessed Code
	6	5	4	3	2	1	N
E.12a Walk 500 ft (1500m): Once standing, can walk at least 500 feet (1500 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐
E.12b Walk 150 ft (45 m): Once standing, can walk at least 150 feet (45 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐
E.12c Walk 50 ft (15 m): Once standing, can walk at least 50 feet (15 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐
E.12d Walk in room once standing: Once standing, can walk at least 10 feet (3 meters) in room, corridor or similar space.	☐	☐	☐	☐	☐	☐	☐

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 6 = Independent 1 = Dependent						Activity Not Assessed Code
	6	5	4	3	2	1	N
E.13a Wheel 500 ft (1500 m): Once seated, can wheel at least 500 feet (1500 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐
E.13b Wheel 150 ft (45 m): Once seated, can	☐	☐	☐	☐	☐	☐	☐

2D Provider Barcode

	wheel at least 150 feet (45 meters) in corridor or similar space.							
E.13c	**Wheel 50 ft (15 m):** Once seated, can wheel at least 50 feet (15 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐
E.13d	**Wheel in room once seated:** Once seated, can wheel at least 10 feet (3 meters) in room, corridor, or similar space.	☐	☐	☐	☐	☐	☐	☐

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 6 = Independent 1 = Dependent						Activity Not Assessed 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.	☐	☐	☐	☐	☐	☐	☐
F.2 Make light meal: The ability to plan and prepare all aspects of a light meal such as a sandwich and cold drink.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐

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III. Provider Information (cont.)

G. Conditions/Impairments

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

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 Diet Modification	G.4c Level of Cueing or Assistance
☐ Both Liquids & Solids	☐ Maximal
☐ Either Liquids or Solids	☐ Moderate
☐ None	☐ Minimal
	☐ 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.

2D Provider Barcode

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 Without Assistance	**G.6c With Assistance**	**G.6d Without Assistance**	**G.6e With Assistance**
Never or Rarely	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually	☐	☐	☐	☐
Always	☐	☐	☐	☐

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

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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	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually	☐	☐	☐	☐
Always	☐	☐	☐	☐

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	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually	☐	☐	☐	☐
Always	☐	☐	☐	☐

2D Provider Barcode

CARE C ADMISSION/INTAKE QUESTIONNAIRE

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

2D Provider Barcode

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:

Basic Information: Simple 1-step directions; simple yes/no questions; simple words or short phrases

Complex Information: 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	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually	☐	☐	☐	☐
Always	☐	☐	☐	☐

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

2D Provider Barcode

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: Basic information regarding wants/needs or daily routines; using 1-2 words or short phrases

Complex Information: Thoughts/ideas using sentences; in conversations about routine daily activities or a variety of topics

	Basic Information		Complex Information	
	G.11b Without Assistance	G.11c With Assistance	G.11d Without Assistance	G.11e With Assistance
Never or Rarely	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually	☐	☐	☐	☐
Always	☐	☐	☐	☐

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: Spontaneous production of automatic words, predictable single words, or short phrases in conversation

Intelligible in Longer Utterances: Spontaneous production of multisyllabic words in sentences

	Intelligible in Short Utterances		Intelligible in Longer Utterances	
	G.12b Without Assistance	G.12c With Assistance	G.12d Without Assistance	G.12e With Assistance
Never or Rarely	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually	☐	☐	☐	☐
Always	☐	☐	☐	☐

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

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

	Low Vocal Demand		High Vocal Demand	
	G.13b Without Assistance	**G.13c With Assistance**	**G.13d Without Assistance**	**G.13e With Assistance**
Never or Rarely	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually	☐	☐	☐	☐
Always	☐	☐	☐	☐

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 Please indicate the frequency of the patient's bladder and bowel incontinence. (Check one box in each column.)

Check one box G.15c Bladder	**Check one box G.15d Bowel**	
☐		Stress Incontinence Only
☐	☐	Incontinent Less Than Daily
☐	☐	Incontinent Daily
☐	☐	Always Incontinent
☐	☐	No Urine/Bowel Output
☐	☐	Not Applicable

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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.**

H.1 Body Functions (Check at least one)

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

H.2 Body Structures (Check at least one)

Structures Related to Movement

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

L: Left Side; R: Right Side

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

Structures Involved in Voice, Speech, & Swallowing

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

Other Structures

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

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

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

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

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

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.

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