Daily Medicare Questionnaire

Please fill out the following questions so we may determine the medical necessity of your care.

1. Are you here for routine care of a chronic condition which is not expected to improve with your treatment today? ☐ YES (NOT COVERED) ☐ NO (COVERED)

2. Do you have a specific complaint today, whether chronic or acute, that will benefit from treatment?
   ☐ YES ☐ NO

3. What is/are your complaints (Check all that apply):

☐ NECK	☐ DULL or ACHY
☐ UPPER BACK	☐ STIFF or TIGHT
☐ MIDDLE BACK	☐ SORE or PAIN
☐ LOWER BACK	☐ SHARP or STABBING
☐ HEADACHE	☐ BURNING
☐ HIP, ARM/HAND, LEG/FOOT	☐ NUMB or TINGLING

4. Rate your pain intensity on the following scale: (circle)

0	1	2	3	4	5	6	7	8	9	10	>10
NOPAIN											MOST PAIN

5. How is this condition/symptom affecting your activities of daily living?

	GOOD	MILD	MODERATE	SEVERE		GOOD	MILD	MODERATE	SEVERE
Sitting	○	○	○	○	Grocery shopping	○	○	○	○
Raising out of chair	○	○	○	○	Household chores	○	○	○	○
Standing	○	○	○	○	Lifting objects	○	○	○	○
Walking	○	○	○	○	Reaching overhead	○	○	○	○
Lying down	○	○	○	○	Showering or bathing	○	○	○	○
Bending over	○	○	○	○	Dressing myself	○	○	○	○
Climbing stairs	○	○	○	○	Love life	○	○	○	○
Using a computer	○	○	○	○	Getting to sleep	○	○	○	○
Getting in/out of car	○	○	○	○	Staying asleep	○	○	○	○
Driving a car	○	○	○	○	Concentrating	○	○	○	○
Looking over shoulder	○	○	○	○	Exercising	○	○	○	○
Caring for family	○	○	○	○	Yard work	○	○	○	○

6. Since your last visit have there been any changes to: (Please Specify or write "No Change")

1. Medications:
2. Surgeries:
3. Diseases/Illnesses:

Date:

Name: _____

Signed: _____