Massage Therapy Treatment Questionnaire

Patient Name: _____ **Visit Date:** _____

Your insurance has implemented a medical necessity review process that requires this information to ensure their members are receiving appropriate care and to assist them in managing your benefits.

Medical necessity is defined as:

- Significant, lasting therapeutic benefits that lead towards a *resolution* of the patient's complaints.
- Functional improvement as the result of massage therapy treatment
- Patient must have at least one functional limitation AND at least one pain complaint.

Please note: Massage Therapy for Preventive, Maintenance or Wellness Care is *NOT* considered medically necessary by the guidelines listed above and therefore not a covered benefit of your plan.

Please answer the questions listed below to the best of your ability to help us establish medical necessity and obtain authorization from your insurance carrier for your massage therapy treatment today.

Please check which applies to today's visit:

- ☐ I have ***not*** had massage therapy treatment in the past 60 days.
- ☐ I am seeking treatment for additional care of the same condition treated within the last 60 days.
  What is the result of your continuing care? ☐ ***Improving*** ☐ ***Same*** ☐ ***Worse***
- ☐ I am seeking treatment for a new or different condition from my last visit.
  What was the result of your previous treatment? ☐ ***Resolved*** ☐ ***Ongoing***

How long have you had this condition? ☐ 0-5 weeks ☐ 6-12 weeks ☐ over 12 weeks ☐ unknown

What is your pain intensity today? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What percentage of time do you experience the pain? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

What is your primary area of complaint? (Check all that apply) ☐ R / L Arm ☐ R / L Leg ☐ Other
☐ Head/Cervical Spine ☐ Upper Back/Thoracic Spine ☐ Lower Back/Lumbar Spine

On a scale of 0-4 (0 = no pain, 4 = severe pain), please indicate your functional deficits associated with your pain. (Circle all that apply)

Standing:	0	1	2	3	4	Driving:	0	1	2	3	4
Walking:	0	1	2	3	4	Recreation:	0	1	2	3	4
Lifting:	0	1	2	3	4	Work:	0	1	2	3	4
Sleeping:	0	1	2	3	4	Housework:	0	1	2	3	4
Sitting:	0	1	2	3	4	Yardwork:	0	1	2	3	4
Climbing Stairs:	0	1	2	3	4	Personal Care:	0	1	2	3	4

Patient Signature _____ Date: _____