MEDICAL NECESSITY CRITERIA OR REVIEW

Insurance requires that medical necessity be established in order to use them for payment. This questionnaire is intended to establish or review criteria or documentation purposes.

Check all that apply within the past 12 months. Rate on the scale as follows:

0 Never 1 rarely 2 periodic 3 sometimes 4 often 5 mostly

___ Difficulty sleeping

___ Appetite change

___ Weight loss or gain
Circle which

___ Sad

___ Tearful

___ Irritable

___ No interest, joy

___ Withdrawn

___ Difficulty concentrating

___ Light headed

___ Heart palpitations

___ sleep walking

___ lose track of time

___ Recent stress

___ Recent trauma

___ flashbacks to trauma

___ nightmares

___ frequent waking

___ recent illness

___ ongoing illness, injury

___ unable sit still

___ unable complete tasks

___ feel shaky inside

___ nervous with others

___ nervous in crowds

___ worry about illness, death

___ obsessions, compulsions
specify

___ phobia of situation, something
Specify

___ heart palpitations

___ sweaty palms

___ difficulty breathing

___ excessive worry

___ suicidal thoughts
Specify if plan

___ excessive anger
Specify if particular target, plan

___ Concerns with children

___ Concerns with spouse, significant relationship

___ Recent loss

___ Anticipated loss

___ Binge eating
How often

___ Not eating by choice
Duration, what taken

___ Purge food (vomit, laxatives)
frequency

___ alcohol use
Amount/frequency

___ non prescription drug use
Type, amount, frequency

____ prescription not followed
Type, amount, frequency yours or other

____ difficulty attending work or school

____ difficulty completing daily activities

____ excessive muscle, joint soreness

____ worry about illness

____ physical symptoms
Type, duration

_____ negative thoughts, self image

_____ picking at sores, scabs

____ excessive spending

____ grandiose thoughts

____ action without thoughts for safety

____ frequent medical/ER visits

____ non medical hospitalizations