# *LAKE COUNTRY PHYSICAL THERAPY & SPORTSCARE, P.C.*

**241 Parrish Street, Suite A, Canandaigua, New York 14424**
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Dear ________________________,

There are questions in this packet which are personal and very private. The answers to these questions assist your provider in developing a plan of care which will help you meet your goals the fastest. If you are not comfortable answering the question then leave it blank and your provider will explain why such questions are asked at your first session.

1) **Print your answers clearly (please due not use cursive).**

1) **Include your lifetime history for your entire body,** not just the areas where you now have problems. Falls, traumas, infections, inflammations and surgeries we sustain during our lives can affect distant parts of the body, many years later.

1) **Include any pain you experience.** This can be very important if you will be filing for insurance reimbursement.

1) **Thank you for taking the time to complete this questionnaire. Bring this questionnaire with you to your first appointment. You are scheduled at ____________________ on ____________________. You will be seen by ______________________________.**

1) **We look forward to helping you attain your goals.**

1) **Feel free to have someone join you if it would make you feel more comfortable.**

_____________________________________________

*Zoe Fackelman, PT*

# *PATIENT QUESTIONAIRE*

## Please circle all appropriate choices in italics.

Name_______________________________ Physician_______________________________
Home Address_______________________________ Address_______________________________
City/State/Zip_______________________________ City/State/Zip_______________________________
Home Phone _______________________________ Phone_______________________________
Cell____________________ Email______________________ Fax_______________________________
What is your preferred contact method?_______________________________________________
**Age**_____**Date of birth**__________**Height**________**Weight**_________**Profession**______________
**Marital Status:** *Married / Single / Divorced /Widowed*
**Ethnic:** *Caucasian / African American / Latin / Asian / Native American / Arabic / Other:* ______
**Do you have specific religious beliefs or customs which may need to be considered for your treatment? Expl:**
_______________________________________________________________
**Education:** High School_______ years College_______ years Graduate school_______ years

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## *PLEASE LIST ALL PAIN COMPLAINTS AND SYMPTOMS HERE:*

**My worst pain area is my**______________________________ Duration:____________________
My usual pain in this area is (none) 0 1 2 3 4 5 6 7 8 9 10 (severe) Best: #_____ Worst#______
My pain in this area is *constant / intermittent / dull aching / sharp shooting / burning / tight / pressure*

**My next to worst pain area is my**________________________ Duration:____________________
My usual pain in this area is (none) 0 1 2 3 4 5 6 7 8 9 10 (severe) Best: #_____ Worst#______
My pain in this area is *constant / intermittent / dull aching / sharp shooting / burning / tight / pressure*

**Other pain areas include**______________________________ Duration:____________________
My usual pain in this area is (none) 0 1 2 3 4 5 6 7 8 9 10 (severe) Best: #_____ Worst#______
My pain in this area is *constant / intermittent / dull aching / sharp shooting / burning / tight / pressure*

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**PAIN OCCURRENCE:** (check only one)
__ P1, pain one day or less per month
__ P2, pain two days or more per month
__ P3, pain one day or more per week
__ P4, daily pain that comes and goes
__ P5, constant pain

**RESPONSE TO MEDICATION:** (check only one)
__ R1, pain goes away with a little medication
__ R2, pain decreases some with one medication
__ R3, pain completely relieved with medication
__ R4, pain decreases some with regular medication
__ R5, nothing decreases the pain

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**I have pain / pressure in my** *head / neck / L/R shoulder / upper back / low back / tail bone / L/R hip / L/R buttock / groin / abdomen / L/R leg / L/R knee / L/R Foot Other:*______________________________
**Are you experiencing any weakness?** *Yes/No.* ***Where?***______________________________
**Are you experiencing any tingling or pins & needles sensation?** *Yes/No* **Where?** ________________
**Are you experiencing any numbness?** *Yes/No* **Where?**______________________________

**How would you rate the severity of your problem?** (Not a problem) 0 1 2 3 4 5 6 7 8 9 10 (major problem)
**How would you rate the degree the problem is controlling your life** (not at all) 0 1 2 3 4 5 6 7 8 9 10 (severe)
**List the activities you cannot do because of this problem**
_______________________________________________________________

<u>**DESCRIBE YOUR PAIN**</u>

**My pain began** *gradually/suddenly* on (date):______________ **Due to**__________________________

_______________________________________________________________

**Pain began in the**_____________________ **and spread to the** ____________________________

_______________________________________________________________

**Since onset, pain has** *increased / decreased / stayed the same in severity / frequency / duration.*
**Pain increases with:** *lifting / sitting / standing / walking / bending / climbing / driving / sexual intercourse/ reaching / housekeeping / social activities / cold / rainy weather / sneezing / deep breathing/ coughing.*
**Pain decreases with:** *rest / ice / heat / postural or positional changes / other* ___________________
**Upon arising, I am:** *stiff / sore / aching / tight / other* ____________________________________
**Once I move around, I feel:** *better / worse*_______________________________________
**By the end of the day, I feel** *better / worse*______________________________________
**At night, my pain:** *increases / decreases*_________________________________________
**The pain pulls into my** *low back / crotch / groin / hip / sciatic area / abdomen / sacroiliac joint(s)* ____
**I experience:** *painful intercourse / loss of libido / joint pain / difficulty or inability to orgasm / declining quality of sexual relationships.* **How often? How recently? How long has this been happening?**

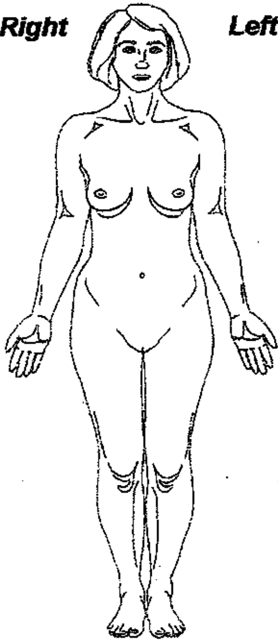
_______________________________________________________________________________

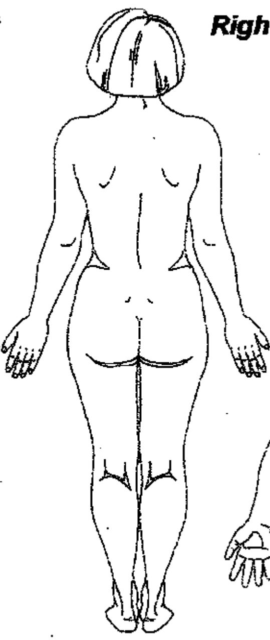
___________________________________________________________

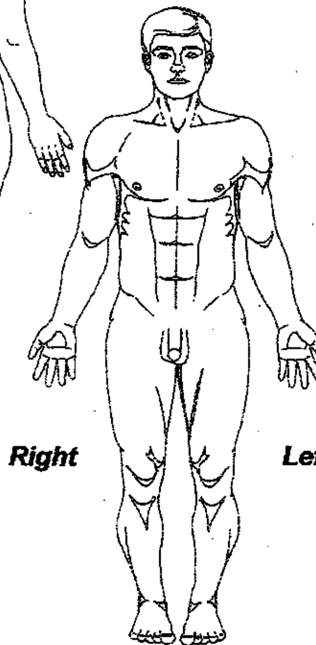
_______________________________________________________________________________

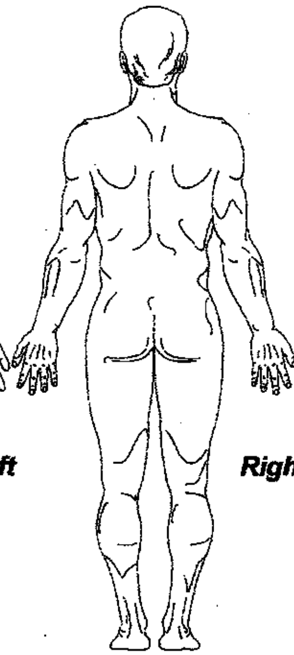
**Mark your areas of pain on the figures below, as follows:**

**////** **numbness** **XXXX** **severe pain** **OOOO** **moderate pain** **→ shooting pain**









## DESCRIBE YOUR USUAL FUNCTIONAL ACTIVITY LEVELS

(Place an "x" to show your daily activity level, compared to complete and normal function)

| | **Inactive** | **25%** | **50%** | **75%** | **Normal** |
|---|---|---|---|---|---|
| On a good day | 0------------------------------------------------------------------100% | | | | |
| On a bad day | 0------------------------------------------------------------------100% | | | | |
| Average | 0------------------------------------------------------------------100% | | | | |

**Are you able to work?** *Yes / no*

**How many hours a week do you work?** ____________________________________

**What type of work do you do?** ____________________________________________

**Do you like your job?** *Yes / no*

**Are you retired?** *Yes / no* **What type of work did you do?** _______________________

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## DAILY JOB AND LIFESTYLE REQUIREMENTS

(Circle your usual daily activities)

**Lifting:** *light / moderate / heavy*

| | |
|---|---|
| 5 lbs frequently | 10 lbs frequently |
| 25 lbs frequently | 50 lbs frequently |
| 10 lbs occasionally | 25 lbs occasionally |
| 50 lbs occasionally | 100 lbs occasionally |

**Standing:** 2 hrs 4hrs 6hrs 8hrs

**Sitting:** 2 hrs 4hrs 6hrs 8hrs

**Walking:** less than 100 feet / 500 feet / ¼ mile

15 min. / 30 min. / 45 min. / 60 min. / 60 min +

**Bending:** *none / occasional / frequent*

**Climbing:** *none/ occasional / frequent*

**Reaching:** *none / occasional / frequent*

**Type of reaching:** *floor to waist* *waist to shoulder* *overhead*

**Do you live alone?** Yes / no

**Do you have help with daily chores around the house?** Yes / no

## BLADDER HABITS

**Have you experienced changes in bladder habits?** *Yes/No ... pain / urgency / frequency /incontinence*

**What tests have you had and when?** ______________________________________________

**Are you able to urinate at the toilet?** *Yes / No*

**How often do you urinate in the day? ___ # of times**

**How many hours pass between visits to the toilet?** _____________ *Hours*

**How often do you urinate after going to bed? ___ # of times**

**What wakes you?** *Your bladder / your mind / your pet / your spouse?*

**Do you take your time to go to the toilet and empty your bladder?** *Yes / No*

**Do you strain to pass urine?** *Yes / No*

**Do you have a slow or hesitant stream?** *Yes / No*

**Do you have difficulty initiating the urine stream?** *Yes / No*

**Can you stop the flow of urine when on the toilet?** *Yes / No*

**Is the volume of urine usually?** *Large / Average / Small / Very Small*

**Is there pain or burning when you urinate?** *Yes / No*

**Do you experience an urge or a sensation to urinate?** *Yes / No*

**Do you leak urine when you experience an urge or sensation to urinate?** *Yes / No*

**Do you empty your bladder "just in case" before you leave the house?** *Yes / No*

**Do you have the feeling your bladder is still full after urinating?** *Yes / No*

**Do you urinate, cleanse, stand up and get the urge to urinate again?** *Yes / No*

**Do you experience dribbling after urinating?** *Yes / No*

**Do you soil your bed clothing and linens with urine?** Yes/ No

**Are you sexually active?** *Yes / No* **Do you climax?** *Yes / No*

**Do you leak urine when you climax?** *Yes / No*

**Do you have "triggers" that make you feel like you cannot wait to get to the toilet?** *Yes / No*

**What are the "triggers"?** ______________________________________________

**How many bladder leakages do you experience in a day?** *Number of episodes*

*Never / only with a strong cough or sneeze / only premenstrual / Constant leakage*

__ *times per day* __ *times per week* __ *times per month*

**What is the severity of the leakage?** *No leakage / few drops / soils underwear / soils outerwear*

**What protection is worn during the day?** *None / Tissue paper / Paper towel / Pantishields / Minipads / Maxipads / Specialty product / Diaper*

**How many times do you change the protection in a day?** _____________ *times.*

**Do you change the protection because** *it is wet? / for hygiene purposes?*

**What protection is worn at night?** *None / Tissue paper / Paper towel / Pantishields / Minipads / Maxipads / Specialty product / Diaper*

**How many times do you change the protection at night?** _____________ *times.*

Please circle letters for: Never, Once, Sometimes, Frequent, Always) Or Indicate Yes, No, location & date problem occurred

| Condition | Response | Condition | Response |
|---|---|---|---|
| High Blood Pressure | **N-O-S-F-A** | Trouble Emptying Bladder/Bowels | **N-O-S-F-A** |
| Angina/chest pain | **N-O-S-F-A** | Constant Dribbling of Urine | **N-O-S-F-A** |
| Heart Arrhythmia | **N-O-S-F-A** | Blood in Urine/Stool | **N-O-S-F-A** |
| Heart Disease | **Y/N Date:** | Bladder/Bowel Cancer | **Y/N Date:** |
| Stroke | **Y/N Date:** | Childhood Bladder/Bowel Problems | **N-O-S-F-A** |
| Pacemaker/metal implant | **Y/N Date:** | Uterine Fibroids | **N-O-S-F-A** |
| Asthma/Emphysema | **Y/N Date:** | Hormonal Problems | **N-O-S-F-A** |
| Shortness of Breath | **N-O-S-F-A** | Infertility | **Y/N** |
| Chronic Cough | **N-O-S-F-A** | Endometriosis | **Y/N** |
| Elevated Cholesterol | **Y/N** | Pelvic Inflammatory Disease | **Y/N** |
| Circulation Problems | **Y/N** | Pelvic or Abdominal Adhesions | **Y/N** |
| Blood Clots | **Y/N Date:** | Abdominal Pain | **N-O-S-F-A** |
| Seizures | **Y/N Date:** | Pelvic Pain / Pressure | **N-O-S-F-A** |
| Cancer | **Y/N Date/Location:** | Difficulty Sitting | **N-O-S-F-A** |
| Tumor | **Y/N Date/Location:** | Painful Intercourse | **N-O-S-F-A** |
| Cysts | **N-O-S-F-A** | Vaginal Dryness/Burning/Itching | **N-O-S-F-A** |
| Systemic Lupus | **Y/N** | Vaginal Infection | **Y/N** |
| Hemophilia | **Y/N** | Sexually Transmitted Disease | **Y/N** |
| Hepatitis | **Y/N** | HIV/AIDS | **Y/N** |
| Liver Disorder | **Y/N** | Perimenopausal symptoms | **Y/N** |
| Yellow Jaundice | **Y/N** | Post-menopausal symptoms | **Y/N** |
| Gall Stones | **Y/N** | Depression | **N-O-S-F-A** |
| Diabetes | **Y/N Type:** | Anxiety | **N-O-S-F-A** |
| Thyroid Problems | **Y/N** | Hemorrhoids | **N-O-S-F-A** |
| Drug/alcohol/tobacco/dependence | **Y/N** | Anal Fissures | **N-O-S-F-A** |
| Recent unexplained weight loss | **Y/N** | Vaginal/Perineal skin cracking/bleeding | **N-O-S-F-A** |
| Recent unexplained weight gain | **Y/N** | Polyps | **N-O-S-F-A** |
| Loss of appetite | **N-O-S-F-A** | Constipation | **N-O-S-F-A** |
| Mononucleosis | **Y/N** | Diarrhea | **N-O-S-F-A** |
| Fatigue | **N-O-S-F-A** | Irritable Bowel Syndrome | **N-O-S-F-A** |
| Allergies (seasonal/otherwise) | **N-O-S-F-A** | Diverticulitis | **N-O-S-F-A** |
| Headaches | **N-O-S-F-A** | Trouble Holding Back Gas | **N-O-S-F-A** |
| Hearing/Vision impaired | **Y/N** | Prostate problems | **N-O-S-F-A** |
| Cataracts | **Y/N** | Low back pain / sciatica | **N-O-S-F-A** |
| Glaucoma | **Y/N** | Osteoarthritis | **N-O-S-F-A** |
| Dizziness | **N-O-S-F-A** | Arthritis | **N-O-S-F-A** |
| Neurological Disorder | **N-O-S-F-A** | Artificial Joints / Pins | **Y/N Date/Location:** |
| Neuropathy | **Y/N** | Joint Problems | **N-O-S-F-A** |
| Gout | **N-O-S-F-A** | Rheumatoid arthritis | **N-O-S-F-A** |
| Anemia | **N-O-S-F-A** | Fibromyalgia | **Y/N** |
| Skin sensitivities | **N-O-S-F-A** | Osteoporosis | **Y/N** |
| Cold Hands and Feet | **N-O-S-F-A** | Multiple Sclerosis | **N-O-S-F-A** |
| Latex allergy | **Y/N** | Have you had a bone density scan? | **N-O-S-F-A** |
| Urinary/bladder/kidney infections | **N-O-S-F-A** | Have you broken any bones? | **N-O-S-F-A** |
| Kidney Stones | **Y/N Date:** | Hernia | **Y/N Location:** |
| Interstitial Cystitis | **N-O-S-F-A** | Acid Reflux / Heartburn | **N-O-S-F-A** |
| Urinary/bowel urgency/frequency | **N-O-S-F-A** | Head Trauma | **Y/N** |
| Urinary or bowel loss of control | **N-O-S-F-A** | Spinal Cord Injury | **Y/N** |
| Trouble Feeling Bladder Fullness | **N-O-S-F-A** | Do you lose consciousness? | **N-O-S-F-A** |
| Trouble Initiating Urine Stream | **N-O-S-F-A** | Memory problems | **N-O-S-F-A** |

Do you have an active infection? *Yes / No* Where? ________________ Are you taking medication? *Yes / No*

## FEMALES ONLY

**Menstruation History:** Age (in years) at first menstrual period .......................... __________
First day of your last period ____________________
Frequency of your period (in days) ...................................................... every _____ days.
How long do your periods last (in days) ................................................... __________
Do you ever experience pain with your periods? ................................. Y / N
If yes do you need medication? .................................................. Y / N
Do you ever experience missed periods? ........................................ Y / N
**Pregnancy History:** How many pregnancies have you had? .............................. __________
How many were full term? ........................................................................ __________
Vaginal deliveries # ________________ Episiotomies # ____________________
Difficult childbirth # ________________
Cesarean section # ________________
How many tubal pregnancies? ................................................................ __________
How many abortions? __________ when? __________
How many miscarriages? __________ when? __________
How many D & C? __________ when? __________
Have you ever used a self-administered early pregnancy test? .................. yes / no / unsure
**Miscellaneous History:**
Hormone replacement therapy – start date ________________
Estrogen replacement therapy – start date ________________
Have you ever had an IUD? Y / N Which kind, when, and for how long?

***DESCRIBE ANY CYSTS:*** Intermittent - Chronic - Chocolate - Gestational

***Location and Size:*** L ovary ________ R ovary ________

## MALES ONLY

| | | |
|---|---|---|
| Have you had your PSA checked? | Y / N | When ______________________________ |
| Prostrate problems now or in the past? | Y / N | When ______________________________ |
| Painful erections? | Y / N | |
| Difficulty getting an erection? | Y / N | |
| Difficulty maintaining an erection? | Y / N | |
| Do you ejaculate? | Y / N | |

## SEXUALITY HABITS

Are you sexually active Y / N
Is your partner(s) male or female? ____________________________
Are you monogamous or with multiple partners?
Do you masturbate?
Do you have pain with sexual intercourse? With penetration/thrusting/both
Do you climax? Y / N

## What causes the leakage?

*(Use an "X" or circle your answers)*

__*Vigorous activity or exercise (running, weight lifting)?*
__ *Light activity (walking, light housework)?*
__*Changing positions (sit to stand, rolling in bed)?*
__ *When I experience a strong urge?*
__ *Activity does not affect leakage (constant despite activity)*
__ *See, hear, or feel water*
__ *Walking to the toilet?*
__ *When your bladder is full?*
__ *Intercourse or sexual activity?*
__ *Coughing / Sneezing / Laughing?*
__ *Certain Foods*

**What position will you leak urine?** *Lying down / Sitting / Standing*

**How long can you delay the need to urinate?** *Not at all / 1-2 min. / 3-10 min. / 11-30 min. / 31-60 min. / hours*

**Do you experience pressure, pelvic heaviness or a feeling like something is falling into your underwear?** *Yes / No*

**How much of each beverage do you consume in a day?**
*water* _____ *caffeine* _____ *diet soda* _____ *regular soda* _____ *alcohol* _____ *coffee/tea*_____
*decaf coffee/tea*_____ *fruit juice* _____ *what type of fruit juice?* ________________________

## BOWEL HABITS

**What is the frequency of your bowel movements (BM)?** ____*per day* ____*per week*

**What is the consistency of the BM?** *Watery / Chunky / Toothpaste / Hard*

**Do you experience constipation?** *Yes / No*

**Do you experience explosive diarrhea?** *Yes / No*

**Do you alternate between diarrhea and constipation depending on the foods you eat?** *Yes / No*

**Do you have pain with your BM?** *Yes / No*

**Do you experience bleeding with your BM?** *Yes / No*

**Do you experience with your BM** *burning / itching / aching / sharp pain / stabbing pain?*

**Does the burning, itching, aching, sharp pain or stabbing pain last long?**
*If yes explain*____________________________________________________________

**Do you strain to have a BM?** *Yes / No*

**Do you ignore the urge to have a BM?** *Yes / No*

**How long can you delay the need to have a BM?**
*Not at all / 1-2 min. / 3-10 min. / 11-30 min. / 31-60 min. /* ______*hours*

**Do you have trouble making it to the toilet on time?** *Yes / No*

**How many bowel leakages do you experience in a day?** *Number of episodes*

*Never / Only with a strong cough or sneeze / Only premenstrual / Constant leakage*

__ *times per day* __ *times per week* __ *times per month*

**Severity of bowel leakage:** *Few drops / Soils underwear / Soils outerwear*

**Do you use a stool softener?** *Yes / No* *If yes what brand?* ____________________

**Do you use a fiber supplement?** *Yes / No* *If yes what brand?* __________________

**Do you use probiotics?** *Yes / No If yes what brand?* ________________________

## INFERTILE WOMEN ONLY

**(This entire page)** Please answer to the best of your acknowledge:

How long have you had unprotected intercourse, without a full-term pregnancy? ......... _____ years

How often do you have sexual intercourse per week? .......... 1 time, 2-3 times, 4-5 times, 6-7 times

Do you know when you are ovulating? ................................. never, sometimes, frequently, always

How has your ovulation been confirmed? (circle).......... basal body temperature, home evaluation test

Ultrasound, progesterone levels, other ______________________________.

**Your hormone levels:** FSH:_____ LH:_____ Estrogen:_____ Progesterone:_____ Thyroid:______

Has your partner had a semen analysis?........Y / N Sperm Count: ________ Normal / Abnormal

Sperm motility: ______ normal / abnormal Testosterone level: high / normal / low

### IDENTIFY ANY OF THESE INFERTILITY TREATMENTS YOU HAVE HAD:

**Clomid** _______ times. Dates ____________ successful / unsuccessful / mixed

Explain ______________________________

**Hormone Treatment** _____ months. Dates ____________ successful / unsuccessful / mixed

Explain ______________________________

**Intrauterine insemination** ______ times. Dates ____________ successful / unsuccessful / mixed

Explain ______________________________

**Surgery to open tubes** ________ times. Dates ____________ successful / unsuccessful / mixed

Explain ______________________________

**In Vitro fertilization** _________ times. Dates ____________ successful / unsuccessful / mixed

Explain ______________________________

**GIFT or other ART? If so, what?** ______________________________

**Are you presently undergoing any treatment for infertility?** Yes, no, unsure, What? ___________

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Date and description of your last medical efforts to become pregnant? Date? ____________________

Description:______________________________

**Could you be pregnant now? ................................................ Yes / no / unsure**

**Tell us what you know about your reproductive system** (circle all app*ropriate choices)*

**Fallopian Tubes:** Describe: ______________________________

**Left:** functional/ scarred / blocked /removed / unsure **Right:** functional/ scarred / blocked /removed / unsure

**Ovaries:** Describe: ______________________________

**Left:** functional/ scarred / blocked /removed / unsure **Right:** functional/ scarred / blocked /removed / unsure

**Fimbriae:** Describe: ______________________________

**Left:** functional/ scarred / blocked /removed / unsure **Right:** functional/ scarred / blocked /removed / unsure

**My Doctor diagnosed the above by: HSG / laparoscopy / hysteroscopy / chromotubation (dye) unsure**

**Have you been told you have pelvic adhesions ........................................................ yes / no / unsure**

How did your physician diagnose the adhesion? ..........................................HSG / laparoscopy / unsure

Were you treated for adhesions? ............................... yes / no / unsure. How?..............................................

**Have you ever been told you have endometriosis?** ................................................yes / no / unsure

How did your physician diagnose the endometriosis?...................................................HSG / laparoscopy

Were you treated for endometriosis? Yes / no / unsure How?______________________________

**Have you ever been told you have PID (pelvic inflammatory disease** ............................ yes / no / unsure

How did you physician diagnosis the PID? ........................................... physical exam / cultures / unsure

Were you treated for PID? yes / no / how

## HISTORY OF SURGERIES AND TRAUMAS, WITH APPROXIMATE DATES:

| | *Date* | | *Date* | | *Date* |
|---|---|---|---|---|---|
| Appendectomy | | Hysterectomy (total / partial) | | Hysteroscopy with or w/out dye | |
| Laparoscopy | | Prostatectomy | | Car Accidents | |
| Gall Bladder Removal | | Back/Spine Surgery | | Falls onto tailbone, back, hip | |
| Surgery to the cervix | | Brain Surgery | | Falls (from horse, bike, etc.) | |
| Bladder Repair | | Pins, plates or screws inserted | | Hit on the head | |
| Abdominal Surgery | | Radiation Therapy | | Physical or Sexual Abuse | |
| Pelvic Surgery | | | | | |
| | | | | | |
| | | | | | |

**Have you had problems or complications from any surgeries or traumatic injuries?**
**Yes / no / unsure** Explain: ____________________________________________

**List any additional tests** you have had regarding present or past medical complaints, the test results or your doctor's medical diagnosis:
________________________________ (date) ______________
________________________________ (date) ______________

**Have you been tested for food intolerances / allergies?** *Yes / No* Date ____________
Results: ______________________________________________________

## LIFESTYLE AND SOCIAL FACTORS

**Circle your stress level on a scale of 1-10, 1 is low and 10 is high ....** 1 2 3 4 5 6 7 8 9 10
Have you had recent major changes in your daily life? (Relationship, death in family, medication, diet, job or other major changes? ________________________________________
Do you sleep well at night?........................................................................................ yes / no
I have trouble........................................ falling asleep, remaining asleep, awaken often
Do you exercise regularly?........................................................................................ yes / no
Hours per week:....................................................................................________
What exercise(s)?________________________________________________
Do you spend more than 20 hours per week combined at a desk, computer and vehicle? yes / no / unsure
Do you fly more than 8 hours a month?...................... yes / no/ unsure
Hours per day you spend outdoors?..........................................0-2, 3-5, 6-8, more than 8
Do you drink alcohol? Yes / No How many ___ *per day* ____ *per week* _____ *per month*
Do you smoke cigarettes? Yes / No How many ___ *per day* ____ *per week* _____ *per month*

| MEDICATIONS / SUPPLEMENTS | START DATE | REASON TAKING |
|---|---|---|

**Patient Name** ______________________ **Account #** ____________ **Date** ___________

What would you like to accomplish by attending physical therapy?

_______________________________________________________________________________

_

Is there anything else you would like to ask or we should know?

_______________________________________________________________________________

_

**WHERE DID YOU HEAR ABOUT LAKE COUNTRY PHYSICAL THERAPY & SPORTSCARE, P.C.?** *(Please mark all that apply)*

*Web Search Engine(Name)*_________________
*Website(Name)*_______________________

*Healthcare Professional(Name)* ___________________

*Flyer(Location)*_________________

*Friend*___________________ *Newspaper Ad*_____________________

*Referral from*______________________
*Newspaper*________________________

*Previous Patient*_____________ *Other*____________________

Did your physician directly refer you to us? Y / N

If not, where did he or she refer you? _____________________________

***THE INFORMATION I HAVE PROVIDED IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND I WILL OBTAIN ANY MEDICAL TEST REULTS THAT RELATE TO MY CONDITION.***

***Patient Signature***__________________________________ ***Date***_______________