LAKE COUNTRY PHYSICAL THERAPY & SPORTSCARE, P.C.

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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?
Explain: _____
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*

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

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
_____

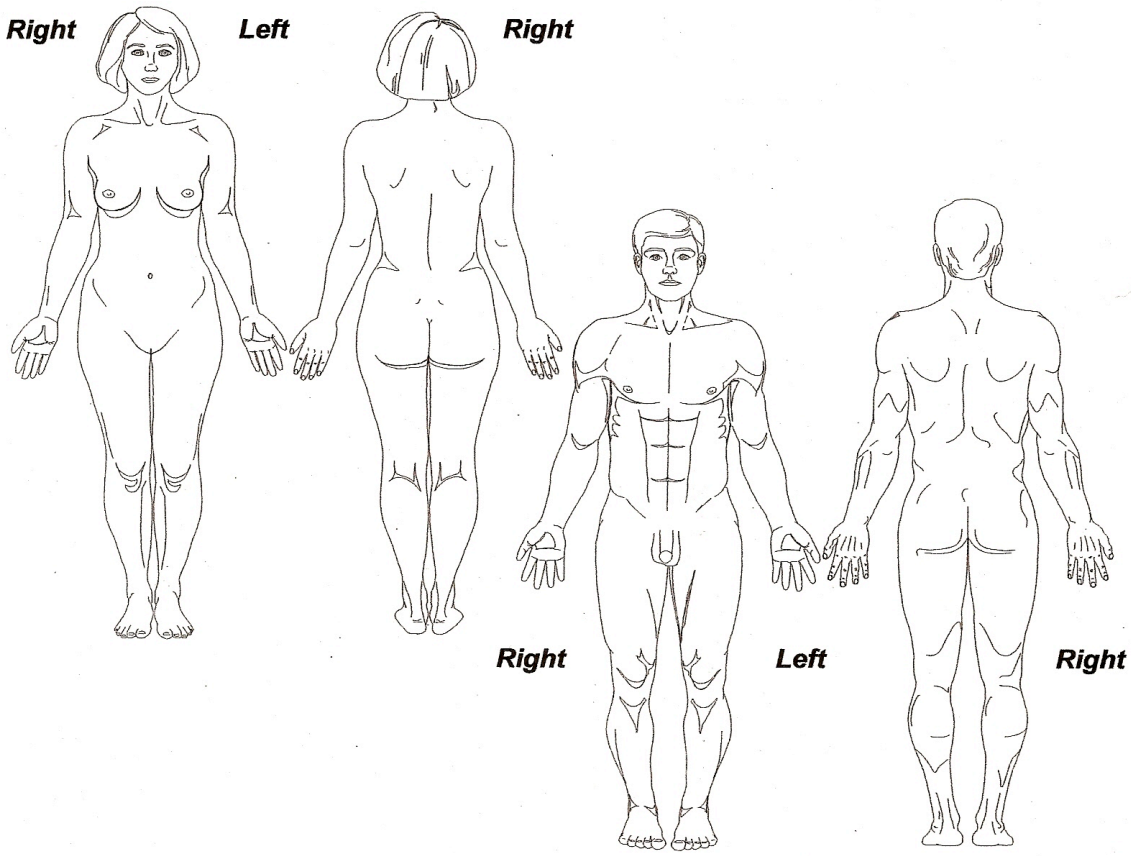
DESCRIBE YOUR PAIN

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?** _____

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.*

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?* _____

Please circle letters for: **N**ever, **O**nce, **S**ometimes, **F**requent, **A**lways) Or Indicate **Y**es, **N**o, location & date problem occurred

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

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? _____

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 appr*opriate 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***_____