

LTCi Questionnaire

1. Name _____
2. Date of Birth _____
3. Spouse/Partner Name _____
4. Spouse/Partner Date of Birth _____
5. State of Residence _____
6. Tobacco Products Used In Last 2 Years? Yes _____ No _____
7. Height _____' _____" Weight _____lbs.
8. Do you have any health conditions? _____
9. Are you currently being treated for a medical condition? _____
Date Diagnosed _____ Describe including medications _____

10. In the Past have you received treatment for a medical condition? _____
Date Diagnosed _____ Describe _____
11. Medications – Dosages – Date Medication Started – Reason? _____

12. When did you last see your doctor? _____
13. What were the results of the visit? _____
14. Has surgery or other test or procedure been discussed or planned? _____
15. Do you have any limitations in performing activities of daily living (eating, bathing, transferring, toileting, continence) or do you suffer from a cognitive impairment? _____
16. Any hospitalizations in the last 5 years? If yes, please explain. _____

17. Do you use any assistive devices? Yes _____ No _____
18. Is physical therapy planned, in process or completed? Yes _____ No _____

Please complete and fax to J. L. Thomas & Company at 216-241-5070.

Please call Phyllis Dall at 800-222-4090 ext.143 with any questions.