

FOTO Patient Intake Form

Lower Back

Staff to Complete

PATIENT NAME: _____ Patient ID: _____

Gender: Male / Female Date of Birth: ____ / ____ / ____ Clinician: _____

Body Part _____ Impairment _____ Care Type _____

Payer Source _____ (Type of Plan such as Preferred Provider, HMO, WC, Auto Insurance, etc.)

Date of Survey: ____ / ____ / ____

The following assessment will ask you about difficulties you may have with certain activities.

It's an important part of your evaluation. It will help us:

- understand how your condition is affecting your activities, and
- develop treatment goals with you.

Please answer the questions with respect to the problem for which we are seeing you. Respond based on how you have been over the past few days.

Today, because of your back problem, do you or would you have any difficulty at all...	Unable to perform	Extreme difficulty	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. Performing any of your usual work, housework, or school activities?						
2. Performing your usual hobbies, recreational, or sporting activities?						
3. Performing heavy activities around your home?						
4. Bending or stooping?						
5. Lifting a box of groceries from the floor?						
Does or would your back problem limit:	Yes, limited a lot	Yes, limited a little	No, not limited at all			
6. Vigorous activities like running, lifting heavy objects, participating in strenuous sports?						
7. Moderate activities like moving a table, pushing a vacuum cleaner, bowling, or playing golf?						
8. Lifting or carrying items like groceries?						
9. Attending social events?						
10. Getting in and out of a chair?						

11. Rate the level of pain you have had in the last 24 hours (please circle response):

0 1 2 3 4 5 6 7 8 9 10
 (None) (Pain as bad as it can be)

12. Please indicate the number of surgeries for your primary condition. None 1 2 3 4+

13. How many days ago did the condition begin? 0-7 days 8-14 15-21 22-90 91 days to 6 mos. Over 6 mos. ago

14. Are you taking prescription medication for this condition? Yes No

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15. Have you received treatments for this condition before? Yes No
16. How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? At least 3 times a week Once or twice per week Seldom or never
17. Other health problems may affect your treatment. Please check (✓) any of the following that apply to you:
- | | |
|--|---|
| <input type="checkbox"/> Arthritis (rheumatoid / osteoarthritis) | <input type="checkbox"/> Visual impairment (such as cataracts, glaucoma, macular degeneration) |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hearing impairment (very hard of hearing, even with hearing aids) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis) |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema | <input type="checkbox"/> Kidney, bladder, prostate, or urination problems |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Previous accidents |
| <input type="checkbox"/> Congestive heart failure (or heart disease) | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart attack (Myocardial infarction) | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anxiety or Panic Disorders |
| <input type="checkbox"/> Neurological Disease (such as Multiple Sclerosis or Parkinson's) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> Other disorders |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Hepatitis, Tuberculosis, HIV, AIDS, or other blood-borne condition |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Prior surgery |
| <input type="checkbox"/> Diabetes Types I and II | <input type="checkbox"/> Prosthesis / Implants |
| <input type="checkbox"/> Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder) | <input type="checkbox"/> Sleep dysfunction |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> None of the above |

18. Height (Required): _____ ft. _____ in.

Weight (Required): _____ lbs.