

# FOTO Patient Intake Survey Shoulder

*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.

How much difficulty do you or would you have using your affected arm to	I can't do this	Much difficulty	Some difficulty	Little difficulty	No difficulty
1. carry a shopping bag or briefcase?					
2. push open a heavy door?					
3. reach an overhead shelf?					
4. lower a lightweight object (1-5 lb) from the top shelf of a closet?					
5. carry a heavy object (over 10 lbs)?					
6. pull a medium weight object (5-10 lbs) from under a bed?					
7. do heavy household chores (e.g., washing walls, washing floors)?					
8. move a heavy skillet (e.g., cast iron skillet) from one stove burner to another?					
9. place a can of soup (1 lb) on a shelf overhead?					
<b>How much difficulty do you or would you have</b>					
10. adjusting the back of your collar with your affected hand?					

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

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.