FOTO Patient Intake Survey
Cranium / Mandible, Thoracic Spine, Ribs

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, does or would your health problem limit:	Yes, limited a lot	Yes, limited a little	No, not limited at all
1. Vigorous activities like running, lifting heavy objects, participating in strenuous sports?			
2. Participating in recreation?			
3. Moderate activities like moving a table or pushing a vacuum cleaner, bowling, or playing golf?			
4. Lifting or carrying items like groceries?			
5. Lifting overhead to a cabinet?			
6. Gripping or opening a can?			
7. Handling small items like pens or coins?			
8. Feeding yourself?			
9. Getting in and out of bed?			
10. Bathing or dressing?			
11. Completing your toileting?			

12. 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)

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

14. 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

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

16. Have you received treatments for this condition before? ☐ Yes ☐ No

Patient Name: _____ Patient ID _____

17. 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

18. Other health problems may affect your treatment. Please check (✓) any of the following that apply to you:

☐ Arthritis (rheumatoid / osteoarthritis)
☐ Osteoporosis
☐ Asthma
☐ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema
☐ Angina
☐ Congestive heart failure (or heart disease)
☐ Heart attack (Myocardial infarction)
☐ High blood pressure
☐ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
☐ Stroke or TIA
☐ Peripheral Vascular Disease
☐ Headaches
☐ Diabetes Types I and II
☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
☐ Pacemaker
☐ Seizures
☐ Visual impairment (such as cataracts, glaucoma, macular degeneration)
☐ Hearing impairment (very hard of hearing, even with hearing aids)
☐ Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
☐ Kidney, bladder, prostate, or urination problems
☐ Previous accidents
☐ Allergies
☐ Incontinence
☐ Anxiety or Panic Disorders
☐ Depression
☐ Other disorders
☐ Hepatitis, Tuberculosis, HIV, AIDS, or other blood-borne condition
☐ Prior surgery
☐ Prosthesis / Implants
☐ Sleep dysfunction
☐ Cancer
☐ None of the above

19. Height (Required): _____ ft. _____ in. Weight (Required): _____ lbs.