FOTO Patient Intake Survey
Generic

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. Participating in rigorous contact sports?			
2. Lifting 100 lbs. or more?			
3. Vigorous activities like running, lifting heavy objects, sports, running more than 5 miles?			
4. Participating in recreation?			
5. Moderate activities, such as moving a table or pushing a vacuum cleaner?			
6. Climbing several flights of stairs?			
7. Climbing one flight of stairs?			
8. Walking more than a mile?			
9. Walking several blocks?			
10. Walking one block?			
11. Going on vacation?			
12. Attending social events?			
13. Lifting or carrying items like groceries?			
14. Lifting overhead to a cabinet?			
15. Gripping or opening a can?			
16. Handling of small items such as a pen or coins?			
17. Feeding yourself?			
18. Getting in and out of bed?			
19. Bathing or dressing?			
20. Bending to the floor?			
21. Kneeling to the floor?			
22. Control of your bladder?			
23. Completing your toileting?			

24. 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)

25. Do you limit the kind of work or other daily activities as a result of your physical health? ☐ No ☐ Yes

26. Do you reduce the amount of time you spend on work or other regular daily activities as a result of your physical health? ☐ No ☐ Yes

27. How much does pain interfere with your normal work (including work outside the home, work around the yard, and housework)? ☐ Extremely ☐ Quite a bit ☐ Moderately ☐ Not at all

28. How much pain have you had in the past 24 hours? ☐ Severe ☐ Moderate ☐ Mild ☐ None

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

30. 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

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

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

33. 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

34. 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

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