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

(oveer please)

Patient Name: _____ Patient ID _____

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:

- ☐ 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

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