

## FOTO Patient Intake Survey

### Neck, 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.)

Insurance \_\_\_\_\_ (Specific Carrier such as Blue Cross, Humana, Aetna, etc.)

Other Referral Code:  Non-PTPN  OPTPN Auto  OPTPN Group Health  OPTPN WC Date of Survey: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

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. 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

Patient Name: \_\_\_\_\_ Patient ID \_\_\_\_\_

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 / AIDS   |
| <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"/> Cancer   |

18. Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.      Weight: \_\_\_\_\_ lbs.

19. This is a statement other patients have made. ***"I should not do physical activities which (might) make my pain worse."*** Please rate your level of agreement with this statement below. (Circle number)

0      1      2      3      4      5      6  
 ▼      ▼      ▼      ▼      ▼      ▼      ▼  
 Completely Disagree      Unsure      Completely Agree