

FOTO Patient Intake Survey Generic

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.

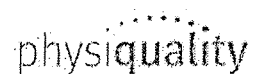
Today, does or would your health problem limit:	Yes, limited a lot	Yes, limited a little	No, not limited at all
1. Participating in rigorous contact sports			
2. Lifting 100 lbs. or more			
3. Vigorous activities like running, lifting heavy objects, sports, running more than 5 miles?			
4. Participating 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:

- | | |
|--|---|
| <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 |

35. Height: _____ ft. _____ in. Weight: _____ lbs.

36. 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. (✓response)

- Completely Disagree Unsure Somewhat Agree Somewhat Disagree Completely Agree