

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 _____ 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, 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. Please indicate the number of surgeries for your primary condition. None 1 2 3 4+
12. 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
13. Are you taking prescription medication for this condition? Yes No
14. Have you received treatments for this condition before? Yes No

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15. 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

16. 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)
 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 / AIDS
 Prior surgery
 Prosthesis / Implants

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

18. 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