

## FOTO Patient Intake Survey Shoulder

*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, how much difficulty do you or would you have...	I can't do this	Much difficulty	Some difficulty	Little difficulty	No difficulty
1. Combing or brushing hair using your affected arm?					
2. Using your affected arm to place a can of soup (1 lb) on a shelf at shoulder height?					
3. Using your affected arm to pick up and drink out of a full water glass?					
4. Using your affected arm to reach a shelf that is at shoulder height?					
5. Using your affected arm to reach an overhead shelf?					
6. Pushing yourself out of a chair using both arms?					
7. Reaching across to the middle of the table with your affected arm to get a salt shaker while sitting?					
8. Getting a scarf or necktie over your head and around your neck, using both hands?					
9. Putting deodorant under the arm opposite your affected shoulder?					
10. Pulling a chair out from a table using your affected arm?					

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:
- |  |   |
|--|---|
| <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)                              |   |
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 |