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.)*
Insurance _____ *(Specific Carrier such as Blue Cross, Humana, Aetna, etc.)*

Other Referral Code: ○ Non-PTPN ○PTPN Auto ○PTPN Group Health ○PTPN 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, 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

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Patient Name: _____ Patient ID _____

14. Are you taking prescription medication for this condition? ☐ Yes ☐ No

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)
- ☐ 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
- ☐ Sleep dysfunction
- ☐ 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*)

- ☐ Completely Disagree
- ☐ Somewhat Disagree
- ☐ Unsure
- ☐ Somewhat Agree
- ☐ Completely Agree

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