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. 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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Patient Name: ______________________________ Patient ID ______________

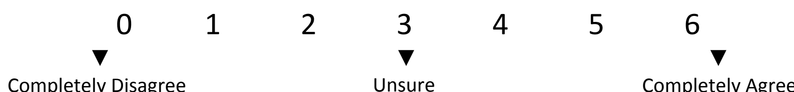
15. How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition?
- ☐ At least 3 times a week
- ☐ Once or twice per week
- ☐ Seldom or never

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
- ☐ Sleep dysfunction
- ☐ Cancer

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*)



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