

## 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  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, 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?   |                           |                              |                               |                     |                            |               |
| <b>Does or would your back problem limit:</b>   | <b>Yes, limited a lot</b> | <b>Yes, limited a little</b> | <b>No, not limited at all</b> |                     |                            |               |
| 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

