

FOTO Patient Intake Survey

Knee

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 affected knee, do you or would you have any difficulty...	Extreme difficulty / Unable to do	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. With any of your usual work, housework, or school activities?					
2. Getting into or out of the bath?					
3. Walking between rooms?					
4. Squatting?					
5. Lifting an object, like a bag of groceries, from the floor?					
6. Performing light activities around your home?					
7. Walking two blocks?					
8. Getting up or down 10 stairs (about 1 flight of stairs)?					
9. Standing for 1 hour?					
10. Running on uneven ground?					

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
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

