

FOTO Patient Intake Survey Medical / Neurological

Staff to Complete

PATIENT NAME: _____ Patient ID: _____

Gender: Male / Female Date of Birth: ____/____/____ Clinician: _____

Body Part _____ Impairment _____ Care Type _____

Payer Source : _____ (ie: Preferred provider, HMO, WC, Medicare B)

Insurance _____ (ie: Blue Cross, Aetna, Humana, 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, does or would your health problem limit:	Yes, limited a lot	Yes, limited a little	No, not limited at all
1. Vigorous activities like running, lifting heavy objects, sports?			
2. Walking more than a mile?			
3. Climbing several flights of stairs?			
4. Moderate activities like moving a table or pushing a vacuum cleaner?			
5. Lifting or carrying items like groceries?			
6. Bending, kneeling, or stooping?			
7. Going on vacation?			
8. Climbing one flight of stairs?			
9. Lifting overhead to a cabinet?			
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

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

