# FOTO Patient Intake Survey
## Neck, Cranium / Mandible, Thoracic Spine, Ribs

*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, 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, participating in strenuous sports? | | | |
| 2. Participating in recreation? | | | |
| 3. Moderate activities like moving a table or pushing a vacuum cleaner, bowling, or playing golf? | | | |
| 4. Lifting or carrying items like groceries? | | | |
| 5. Lifting overhead to a cabinet? | | | |
| 6. Gripping or opening a can? | | | |
| 7. Handling small items like pens or coins? | | | |
| 8. Feeding yourself? | | | |
| 9. Getting in and out of bed? | | | |
| 10. Bathing or dressing? | | | |
| 11. Completing your toileting? | | | |

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

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

15. Have you received treatments for this condition before? ☐ Yes ☐ No

physiquality

PATIENT NAME:_____ DATE OF BIRTH: _____

**MEDICAL HISTORY**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Allergies | ◯ Yes | ◯ No | Depression | ◯ Yes | ◯ No | Kidney Problems | ◯ Yes | ◯ No |
| Anemia | ◯ Yes | ◯ No | Diabetes | ◯ Yes | ◯ No | Metal Implants | ◯ Yes | ◯ No |
| Anxiety | ◯ Yes | ◯ No | Dizzy Spells | ◯ Yes | ◯ No | MRSA | ◯ Yes | ◯ No |
| Arthritis | ◯ Yes | ◯ No | Emphysema/Bronchitis | ◯ Yes | ◯ No | Multiple Sclerosis | ◯ Yes | ◯ No |
| Asthma | ◯ Yes | ◯ No | Fractures | ◯ Yes | ◯ No | Osteoporosis | ◯ Yes | ◯ No |
| Cancer | ◯ Yes | ◯ No | Gallbladder Problems | ◯ Yes | ◯ No | Parkinson's | ◯ Yes | ◯ No |
| Cardiac Conditions | ◯ Yes | ◯ No | Hepatitis | ◯ Yes | ◯ No | Rheumatoid Arthritis | ◯ Yes | ◯ No |
| Cardia Pacemaker | ◯ Yes | ◯ No | High Cholesterol | ◯ Yes | ◯ No | Seizures | ◯ Yes | ◯ No |
| Chemical Dependency | ◯ Yes | ◯ No | High Blood Pressure | ◯ Yes | ◯ No | Strokes | ◯ Yes | ◯ No |
| Circulation Problems | ◯ Yes | ◯ No | HIV/AIDS | ◯ Yes | ◯ No | Thyroid Disease | ◯ Yes | ◯ No |
| Currently Pregnant | ◯ Yes | ◯ No | Incontinence | ◯ Yes | ◯ No | Tuberculosis | ◯ Yes | ◯ No |
| | | | | | | Vision Problems | ◯ Yes | ◯ No |

**Describe any other conditions or precautions:**

**Fall History**

**Injury as a result of a fall in the past year?** ◯ Yes ◯ No **Date of Fall:**_____

**Two or more falls in the last year?** ◯ Yes ◯ No **Date of Falls:**_____

**Surgical History**

Body Region: _____ Surgery Type: _____ Date of Surgery:_____

Body Region: _____ Surgery Type: _____ Date of Surgery:_____

Body Region: _____ Surgery Type: _____ Date of Surgery:_____

Body Region: _____ Surgery Type: _____ Date of Surgery:_____

Body Region: _____ Surgery Type: _____ Date of Surgery:_____

Current Medications

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____