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.)*

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. Rate the level of pain you have had in the last 24 hours *(please circle response)*:

0 1 2 3 4 5 6 7 8 9 10
(None) (Pain as bad as it can be)

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

Patient Name: _____ Patient ID _____

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

16. 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

17. 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

18. Height: _____ ft. _____ in. Weight: _____ lbs.

19. 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.

- ☐ Completely Disagree
- ☐ Somewhat Disagree
- ☐ Unsure
- ☐ Somewhat Agree
- ☐ Completely Agree

OSWESTRY BACK DISABILITY INDEX

This questionnaire is designed to help us better understand how your back pain affects your ability to manage everyday life activities. Please check the box for **THE ONE STATEMENT** in each section that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **MOST CLOSELY** describes your present-day situation. Thank you.

SECTION 1: Pain Intensity
- ☐ **0** My pain is mild to moderate. I do not need pain killers
- ☐ **1** The pain is bad, but I manage without taking pain killers
- ☐ **2** Pain killers give complete relief from pain
- ☐ **3** Pain killers give moderate relief from pain
- ☐ **4** Pain killers give very little relief from pain
- ☐ **5** Pain killers have no effect on the pain

SECTION 2: Personal Care (Washing, Dressing, etc.)
- ☐ **0** I can look after myself without causing extra pain
- ☐ **1** I can look after myself normally but it causes extra pain
- ☐ **2** It is painful to look after myself and I am slow & careful
- ☐ **3** I need some help but manage most of my personal care
- ☐ **4** I need help every day in most aspects of self-care
- ☐ **5** I do not get dressed; wash with difficulty and stay in bed

SECTION 3: Lifting
- ☐ **0** I can lift heavy weights without extra pain
- ☐ **1** I can lift heavy weights, but it causes extra pain
- ☐ **2** Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example on a table
- ☐ **3** Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ **4** I can only lift very light weights
- ☐ **5** I cannot lift or carry anything at all

SECTION 4: Walking
- ☐ **0** I can walk as far as I wish
- ☐ **1** Pain prevents me from walking more than 1 mile
- ☐ **2** Pain prevents me from walking more than ½ mile
- ☐ **3** Pain prevents me from walking more than ¼ mile
- ☐ **4** I can walk only if I use a cane or crutches
- ☐ **5** I am in bed or in a chair for most of the day.

SECTION 5: Sitting
- ☐ **0** I can sit in any chair for as long as I like
- ☐ **1** I can sit in my favorite chair only, but for as long as I like
- ☐ **2** Pain prevents me from sitting for more than 1 hour
- ☐ **3** Pain prevents me from sitting for more than ½ hour
- ☐ **4** Pain prevents me from sitting for more than 10 minutes
- ☐ **5** Pain prevents me from sitting at all

SECTION 6: Standing
- ☐ **0** I can stand as long as I want without extra pain
- ☐ **1** I can stand as long as I want, but it gives me extra pain
- ☐ **2** Pain prevents me from standing for more than 1 hour
- ☐ **3** Pain prevents me from standing for more than ½ hour
- ☐ **4** Pain prevents me from standing for more than 10 minutes
- ☐ **5** Pain prevents me from standing at all

SECTION 7: Sleeping
- ☐ **0** Pain does not prevent me from sleeping well
- ☐ **1** I sleep well but only when taking medication
- ☐ **2** Even when I take medication, I sleep less than 6 hours
- ☐ **3** Even when I take medication, I sleep less than 4 hours
- ☐ **4** Even when I take medication, I sleep less than 2 hours
- ☐ **5** Pain prevents me from sleeping at all

SECTION 8: Social Life
- ☐ **0** Social life is normal and causes me no extra pain
- ☐ **1** Social life is normal, but increases the degree of pain
- ☐ **2** Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- ☐ **3** Pain has restricted my social life, and I do not go out as often
- ☐ **4** Pain has restricted my social life to my home
- ☐ **5** I have no social life because of pain

SECTION 9: Changing Degree of Pain
- ☐ **0** My pain is rapidly getting better
- ☐ **1** My pain fluctuates, but overall is definitely getting better
- ☐ **2** My pain seems to be getting better, but improvement is slow at present
- ☐ **3** My pain is neither getting better or worse
- ☐ **4** My pain is gradually worsening
- ☐ **5** My pain is rapidly worsening

SECTION 10: Traveling
- ☐ **0** I can travel anywhere without extra pain
- ☐ **1** I can travel anywhere, but it gives me extra pain
- ☐ **2** Pain is bad, but I manage journeys over 2 hours
- ☐ **3** Pain restricts me to journeys of less than 1 hour
- ☐ **4** Pain restricts me to necessary journeys under ½ hour
- ☐ **5** Pain prevents traveling except to the doctor/hospital

SCORING:
Simply count up the points and plug the total in below: For each question there is a possible of 5 points: 0 for the first question, 1 for the second question, 2 for the third question etc.