FOTO Patient Intake Survey
Foot, Ankle, Lower Leg (without 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 ○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, because of your affected foot / ankle / lower leg, 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. Lifting an object, like a bag of groceries, from the floor?					
5. Performing light activities around your home?					
6. Performing heavy 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

physiquality

Patient Name: _____ Patient ID _____

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

16. 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

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

18. 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 below. (✓*response*)

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