FOTO Patient History

Staff to Complete

Patient ID: _____ Last Name: _____ Date of Survey: _____ / _____ / _____

1. Other Health problems may influence your treatment, please check any of the following problems that apply to you. If you select a category, please provide more detail by circling the specific issues in the row below.

☐ Lungs or breathing

Asthma Pneumonia TB Emphysema Bronchitis Other None

☐ Blood pressure or heart

Hypertension High Cholesterol Heart Disease Heart Surgery Pacemaker

Angina Heart Murmur Other None

☐ Digestion, bowel, liver, gall bladder

Ulcer Liver Disease Gall Bladder Colon Bowel Other None

☐ Kidney, bladder, prostate, or urination

Kidney disease Bladder disorder Prostate Urination None

☐ Diabetes, thyroid, hypoglycemia

Diabetes Thyroid Hypoglycemia None

☐ Arthritis or other joint disorders

Rheumatoid arthritis Arthritis Lupus Joint replacement

Ligament repair Osteoporosis Fractures Metal Implants

Osteoarthritis Other None

☐ Neurological disorders or headaches

Headaches Seizures Stroke Multiple sclerosis Other None

☐ Hearing disorders

Hard of hearing Deafness Other None

☐ Vision disorders

Blindness Cataracts Peripherally limited vision Low vision Other None

☐ Nervous System Disorders

CVA Parkinson's Disease Alzheimer's Disease Other None

☐ Previous accidents

Automobile Work Other None

☐ Allergies

Soaps Perfumes Dyes Dust / environment Latex Food

Drugs / medications Other None

☐ Incontinence

Bowel Bladder None

☐ Cancer

☐ Vascular Disorders

Venous Arterial Lymphatic None

☐ Mental Health Issues

Depression Anxiety None

☐ Other disorders

☐ None

2. Personal habits influence your treatment; please select your current or past habits:

☐ Smoking
☐ Alcohol
☐ Substance abuse
☐ Other
☐ None

3. Please select the highest level of education you have completed:

☐ 1st Grade ☐ 2nd Grade ☐ 3rd Grade ☐ 4th Grade ☐ 5th Grade ☐ 6th Grade ☐ 7th Grade

☐ 8th Grade ☐ 9th Grade ☐ 10th Grade ☐ 11th Grade ☐ 12th Grade

College: ☐ 1 Year ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 or more years

Post-Graduate: ☐ 1 Year ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 or more years

4. What is your preferred learning style? ***Select as many as you choose.***

☐ Verbal
☐ Reading
☐ Doing
☐ Watching

5. Please select the description of your living situation:

☐ I live at home alone
☐ I live at home with my spouse
☐ I live at home with my spouse and kids
☐ I live at home with others
☐ I live in a community housing such as an assisted living facility
☐ Other

6. Do you have any religious or cultural practices that we should know about?

☐ Yes
☐ No

7. Do you have any special diet that we should know about?

☐ Yes
☐ No

8. **Have you recently had a significant change in your weight?**

- ☐ Yes
- ☐ No

***9. If the answer to #8 is Yes* – Regarding your weight change, was it a…**

- ☐ Gain
- ☐ Loss

10. Is your current problem the result of an accident?

- ☐ Yes
- ☐ No

***11. If the answer #10 is Yes* – Please select the type of accident:**

- ☐ Automobile
- ☐ Work
- ☐ Home
- ☐ Other

***12. If the answer #10 is Yes* – Please give the date of your accident**

_____ / _____ / _____
Month Day Year

13. What testing have you had for this problem? Please also indicate what you were told about any of the tests that you have had.

- ☐ X-Rays
  - ☐ Nothing ☐ There was a problem ☐ There was nothing wrong
- ☐ MRI
  - ☐ Nothing ☐ There was a problem ☐ There was nothing wrong
- ☐ CT Scan
  - ☐ Nothing ☐ There was a problem ☐ There was nothing wrong
- ☐ Myelogram
  - ☐ Nothing ☐ There was a problem ☐ There was nothing wrong
- ☐ None

14. What treatment have you had for this problem? For any of the treatments you have received, please indicate how you were after the treatment.

- ☐ Physical Therapy
  - ☐ Worse ☐ Same ☐ Better
- ☐ Occupational Therapy
  - ☐ Worse ☐ Same ☐ Better
- ☐ Speech Therapy
  - ☐ Worse ☐ Same ☐ Better
- ☐ Chiropractic
  - ☐ Worse ☐ Same ☐ Better
- ☐ Surgery
  - ☐ Worse ☐ Same ☐ Better
- ☐ Acupuncture
  - ☐ Worse ☐ Same ☐ Better
- ☐ None

15. What prescription medications are you taking for this problem?

- ☐ Pain killer
- ☐ Muscle relaxer
- ☐ Antibiotic
- ☐ Anti-Inflammatory
- ☐ Unknown
- ☐ Other
- ☐ None

16. What non-prescription medicine are you taking for this problem?

- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Antacid
- ☐ Other
- ☐ None

17. Since your problem began, describe the current trend of the most prominent symptoms:

- ☐ Getting worse
- ☐ Staying the same
- ☐ Getting better

18. Please mark all of the symptoms you are experiencing.

- ☐ Pain
- ☐ Swelling
- ☐Paralysis
- ☐ Tingling
- ☐ Numbness
- ☐ Other

19. When are you scheduled to see the doctor who referred you here for treatment?

_____ / _____ / _____
Month Day Year

20. *(Female Only)* Are you pregnant?

- ☐ Yes
- ☐ No

21. *(Female Only)* How many children have you delivered? _____

