

Patient Self Assessment Adjustment/Replacement Prosthesis

Name: _____ DOB: _____ Date: _____

Which extremity was amputated: _____ Date of Initial Amputation: _____

Cause of the amputation: _____

After amputation, did you (circle) gain, lose or stay the same weight? If lose/gain, how much? _____

Are you employed? (Circle one) Yes No If No, Would you like to return to work? Yes No

What is or will be your occupation? _____

My living situation is (please circle all that apply):

1) I live alone 2) I live with my family 3) I live in an assisted living facility 4) My residence has stairs

What is the age of the present prosthesis? _____

With my prosthesis, some activities I participate in (please circle all that apply):

- | | |
|--|---|
| 1) Walking or hiking | 6) Jogging or Running |
| 2) Shopping | 7) Golf |
| 3) Family activities | 8) Boating |
| 4) Taking care of my children or grandchildren | 9) Gym |
| 5) Taking care of the house (cleaning/maintenance) | 10) Drive or take public transportation |

Other activities or hobbies I do (please list below): _____

After my amputation, with my prosthesis, I am able to (please circle all that apply):

- | | |
|---|--|
| 1) Walk or transfer safely with or without assistance | 4) I can walk on level surfaces |
| 2) I can walk on uneven surfaces | 5) I can navigate ramps, curbs and stairs |
| 3) I can walk at various speeds | 6) I am involved in sports/exercise programs (Including Physical or Occupational therapy) |

If you did not receive this prosthesis, how would your life be impacted?
