**Prosthetic Intake Form**

**Thank you for taking the time to fill out this form. Please take your time as your answers will help us to better serve you.**

**Name:** Click or tap here to enter text.

**Level of Amputation:**    Right  Left Bilateral

Below knee  Above knee  Partial Foot  Symes  Other: Click or tap here to enter text.

Below Elbow  Above Elbow  Partial Hand  Finger(s)

**Date of amputation MM/DD/YYYY :** Click or tap here to enter text.

**Cause of amputation:**  Trauma  Tumor  Infection  Dysvascular  Congenital  Other:

**Status:**  New Amputee  Existing Amputee

**Types of devices (new amputees only):**

Click or tap here to enter text.

**Other health issues: (diabetes, dysvascular, neuropathy, heart condition, injuries, other)**

Click or tap here to enter text.

**Living Status:**

Alone or without assistance         Home with assistance, Who? Click or tap here to enter text.

Long Term Care Facility         Other: Click or tap here to enter text.

**Environmental Barriers:**  Steps  Stairs  Ramps  Uneven surfaces  Other Click or tap here to enter text.

**Job Status:**  Currently Unemployed  Retired  Disability  If Employed, Job Description:

Click or tap here to enter text.

**How has employment status or job activities been affected by loss of limb?**

Click or tap here to enter text.

**Attending  Physical and/or  Occupational Therapy?** No  Yes  (CLICK TYPE OF THERAPY)

If Yes, Location of therapy: Click or tap here to enter text. Therapist: Click or tap here to enter text.

**Reason for Therapy?**

Pre-Prosthetic Training  Post Prosthetic Training  Other: Click or tap here to enter text.

**New Amputees:**

**Current Mobility Status:**  Using Crutches  Using Walker  Using Wheelchair  Transfer Only

**List the activities that you performed prior to amputation that you want to get back to doing after receiving your prosthesis.**

Click or tap here to enter text.

**Current Prosthetic Users:**

**Mobility Aid used with current prosthesis:**  None  Cane  Forearm/Regular  Crutches

Walker

**List any limitations that you would like addressed with your current prosthesis?**

Click or tap here to enter text.

**Activities that you participate in:**

Walking  Cooking  Shopping  Laundry  Grocery Shopping  Biking  Yard Work

Gardening  Farming  Hiking  Jogging  Basketball  Hunting  Fishing Swimming

Golf  Other: Click or tap here to enter text.

**Current prosthetic users, what improvements would you like to see in your new prosthesis?**

Click or tap here to enter text.

**Anything else you would like to let us know that will help us optimize your prosthetic care:**

Click or tap here to enter text.

**Signature:** **Date:** MM/DD/YYYY

Click or tap here to enter text. Click or tap here to enter text.

Electronically signed by patient.