We want to get to know you! At Prevail, our patient relationships are very important to us. By taking the time to complete this questionnaire, you are allowing us to provide you with the best service possible by helping us to establish your individual needs and goals.

Please complete this form and bring it with you to your appointment. If mailed, please return form in the envelope provided at your earliest convenience.

Getting to know YOU:

Name:_____

1. Are you…
   - ☐ single?
   - ☐ married?
   - ☐ divorced?
   - ☐ widowed?
   - ☐ in a relationship?

2. How many people live in your home? _____
3. Do you have children or grandchildren? _____
4. What are their names and ages?

   _____
5. Do you have any pets? _____ If so, what kind_____
6. What family activities do you enjoy?

   _____
7. What type of individual activities do you enjoy?

   _____
8. Describe the outdoor terrain at your home (hills, sloping yard, gravel, mud, cement drive/walkway, etc):

   _____
9. How many stories does your house have? _____
10. Do you have stairs leading into your home, from outside or from the garage? _____How many stairs?_____
11. Do you have stairs inside your home? _____ How many stairs? _____
12. Do you have ramps? _____ inside, outside, or both? _____
13. Do you have carpet? _____
14. How often do you drive? _____
15. Do you use foot pedals or hand controls when driving? _____
16. How often and what type of exercise do you do?

    _____
17. How much walking do you do each day (in hours or miles)? _____

18. What percentage do you estimate you are standing or are on your feet on any given day? _____
19. Do you run? _____ If so, how often and how far? _____
20. What time do you typically wake up in the morning on weekdays? _____ Weekends? _____
21. Are you employed? _____
    If so, where?_____
    Explain your work environment (carpet, stairs, ramps, elevators, etc):
    _____
    What are your job responsibilities? _____
22. If you're retired or currently without employment, where did you previously work and what were your previous job responsibilities? _____
23. Are you a caregiver for anyone? _____ If so, for who?_____
    What duties do you perform?_____
24. Are you a volunteer? _____If so, where do you volunteer and what do you do?_____
    _____
25. Are you currently living in a nursing facility? _____ If yes, which one?_____

Medical:

1. Do you experience any pain? _____ If so, where?_____
2. At what point during the day you do you experience the most pain?
   _____
3. Rate your pain level at its worst from 1-10, 10 being the worst: _____
4. Rate your pain level at its best from 1-10, 10 being the worst:_____
5. How did you become an amputee?
   _____
6. What date (or year) were you amputated? _____
7. Please rate how difficult the transition of becoming an amputee has been for you from 1-10, 10 being most difficult: _____ If you'd like to share, please explain_____
   _____
8. What activities could you do before your amputation that you would like to do again?
   _____
9. What are some of the goals you hope to accomplish after receiving your prosthesis?
   _____
10. Explain any complications you experienced with your surgery or with healing after your surgery, if any?
    _____
11. Have you ever quit a job because of your amputation? _____
    If so, why?_____
12. What are some of your physical concerns?
    _____
    _____

13. Are you currently using ambulatory aids such as canes, walkers, wheelchairs or crutches? _____
    If yes, which device(s) do you use? _____
14. Have you experienced significant weight loss or gain in the last few months? _____
    Explain: _____
15. Do you experience falls? _____ if so, how often?_____
16. If you live alone, how often do you have visitors? _____
17. What is the date you last saw your doctor?_____
    Did you discuss any problems you are having with regards to your amputation?_____
    If yes, explain:_____
18. If diabetic, who is your diabetic doctor?_____
19. Are you currently or have you participated in any occupational/physical therapy?_____
    If yes, what is/was the name of the facility?_____
20. Who is your primary care physician?_____

For the experienced wearer: (if you've never worn a prosthesis before, please skip this section)

1. When do you initially put your prosthesis on?
   _____
2. How often do you change your liner? _____
3. How often do you change your socks?_____
   What sock ply (or plies) are you wearing and in what combination?_____
   Do you have to add or remove socks at any time during the day?_____
   if so, when?_____
4. When you're not wearing your prosthesis, list any assistive devices you use (canes, walkers, wheelchairs, crutches, etc):
   _____
5. What types of limitations do you have with your prosthesis?
   _____
   _____
6. List any recent problems you've discussed with your doctor regarding your prosthesis:
   _____
   _____

We welcome any additional information you'd like to provide. _____

_____

_____

_____ _____

PATIENT SIGNATURE DATE

Please be assured, this form is for our use only. We will not share any information you provide. We appreciate you taking the time to complete this questionnaire and we thank you for trusting us with your care!