



SEOP

Choice

RPO

## Patient Intake Form

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Phone: \_\_\_\_\_

Zip: \_\_\_\_\_

Shoe Size: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Amputation: \_\_\_\_\_ Level & Side of Amputation: \_\_\_\_\_

Where was your present prosthesis made? \_\_\_\_\_

When was your prosthesis made? \_\_\_\_\_

Please rate your present prosthesis:

	Poor	Fair	Good	Very Good	Excellent
Overall Comfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Functionality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What would make your prosthesis better? (Check all that apply)

Better Fit	Different Foot	Different Knee	Different Suspension	Torque Absorption	Shock Absorption
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

How did you hear about the LLMT event?  Google  Facebook  Instagram  Radio  Other, please explain \_\_\_\_\_

What do you hope to gain or change at this event?

Additional Questions or Comments?



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# Clinical Evaluation Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Prosthetist: \_\_\_\_\_ Practice Location: \_\_\_\_\_

LLMT Prosthetist: \_\_\_\_\_

AK     BK     Left     Right     Bi-lateral

Trials:

	Foot	Category	Size	PT Rating (1-10)
1	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>
2	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>
3	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>

	Knee	PT Rating	Comment
1	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>
2	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>
2	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>

Additional Comments and Other Observations:

## Clinical Evaluation Form

Name: \_\_\_\_\_

### Assessment of Current Prosthesis

	Poor				Excellent	Comment / Notes
Alignment:	1	2	3	4	5	<input type="text"/>
Structural:	1	2	3	4	5	<input type="text"/>
Suspension:	1	2	3	4	5	<input type="text"/>
Height:	tall		short		good	<input type="text"/>
Other:	<input type="text"/>					

### Socket Assessment

#### BELOW KNEE

Excessive Pressure Areas:

- Too Loose   
  Too Tight   
  Fib Head   
  Ant Distal Tibia   
  Condyle   
  Tibia Tubercle   
  Distal End   
  Hamstrings

#### ABOVE KNEE

Excessive Pressure Areas:

- Too Loose   
  Too Tight   
  Distal Femur   
  Ramus   
  Adductor Longus   
  Other   
  IT

### Recommendations:

- New Prosthesis   
  New Socket   
  New Foot   
  New Knee

Type of Suspension

Socket Design

Other