PHYSICAL THERAPY AMPUTEE INITIAL EVALUATION

DATE OF ONSET:_____ ADMISSION DATE ACUTE: _____ REHAB: _____
DATE OF BIRTH: _____ AGE: _____ SEX: _____

MEDICAL DIAGNOSIS: _____
_____

HISTORY OF PRESENT INCIDENT: _____
_____
_____
_____

PAST MEDICAL/SURGICAL HISTORY: _____
_____
_____

SOCIAL/FAMILY HISTORY: _____
_____

MENTAL STATUS: _____
_____

PRECAUTIONS: _____
VITAL SIGNS: BP: _____ HR: _____
PRIOR LEVEL OF FUNCTION: _____
_____

ROM, STRENGTH, SENSATION:

Neck & Trunk: _____
_____
_____

Upper Limbs: _____
_____
_____
_____
_____

Lower Limbs: _____
_____
_____
_____
_____
_____
_____

DESCRIPTION OF RESIDUAL LIMB/PHANTOM SENSATION/PAIN: _____
_____
_____

FUNCTIONAL ACTIVITIES:

Bed Mobility: _____
_____
_____

Balance (sitting/standing): _____
_____

Transfers: _____
_____
_____

Wheelchair Management: _____
_____

Gait: _____
_____
_____

TYPE OF PROSTHESIS/# OF STUMP SOCKS:
socket: _____
knee: _____
foot/ankle: _____
stump socks: _____

SHORT TERM GOALS: _____
_____
_____

LONG TERM GOALS: _____
_____
_____

DISCUSSION OF GOALS AND TREATMENT PLAN WITH PATIENT AND COMMENTS: _____
_____
_____
_____

PLAN OF CARE/TREATMENT: _____
_____
_____

REHABILITATION POTENTIAL: _____
_____

FREQUENCY AND DURATION: _____

PHYSICAL THERAPIST SIGNATURE:_____ DATE: _____