HPI AMPUTEE

History of Present Illness

What level of amputation have you received? (Select all that apply)
☐ foot ☐ below knee ☐ above knee ☐ hand
☐ below elbow ☐ above elbow

Additional Comments:

On what date did this occur?

Which side was affected? ☐ left ☐ right ☐ both

What was the cause of your amputation? (Select all that apply)
☐ vascular disease ☐ diabetes (non-healing wound)
☐ trauma ☐ cancer

Do you have pain? Yes No

Which side? (Select all that apply) ☐ left ☐ right

Where is this pain located? (Select all that apply)
☐ residual limb ☐ intact limb
☐ phantom limb

What makes this pain worse? (Select all that apply)
☐ activity ☐ lifting ☐ lying on back
☐ lying on stomach ☐ pressure on limb ☐ pulling
☐ pushing ☐ reaching ☐ sitting
☐ standing ☐ transfers ☐ walking

What makes this pain better? (Select all that apply)
☐ nothing ☐ rest ☐ ice
☐ immobilization ☐ bracing ☐ splinting
☐ elevation ☐ pain medication ☐ heat

How would you describe this pain? (Select all that apply)
☐ dull ☐ sharp ☐ aching ☐ throbbing
☐ shooting ☐ constant ☐ intermittent

Do you have symptoms of phantom sensation? Yes No

What sensations do you feel? (Select all that apply)
☐ numbness ☐ tingling ☐ itching ☐ cramping

What hand is dominant? (Select one)
○ right handed ○ left handed ○ ambidextrous (both)

Have you had any diagnostic tests done? (Select all that apply) Yes No
☐ ultrasound
☐ doppler

Do you currently have numbness and tingling? Yes No

If yes, where? (Select all that apply)
☐ right upper extremity ☐ left upper extremity ☐ right lower extremity
☐ left lower extremity

Additional Comments:

Home Environment

How would you rate your health? ○ excellent ○ good ○ fair ○ poor

Do you exercise regularly? ○ does ○ does not

How many falls have you had in the past 6 months? ○ 0 ○ 1 to 2 ○ >3

What is your employment status? ○ employed ○ unemployed ○ retired

What do you do for a living?

Do you live alone? ○ alone ○ with someone

Do you require assistance at home? Yes No

Do you have stairs at home? Yes No

If yes, how many? ○ 1-8 ○ 9-15 ○ >15

Where is the railing as you go up the stairs? (Select all that apply) ☐ left ☐ right

Goals/Followup

What are your goals for therapy?

When are you scheduled to return to the doctor for follow-up? ○ as needed ○ within 1 month ○ after completion of therapy

Additional Comments: