RESTORATIVE
PROSTHETICS & ORTHOTICS

Patient Evaluation Form

(completed by patient)

Please complete the following questionnaire as it relates to your job, hobbies and tasks around your home. This will assist your healthcare team in documenting the necessary information to illustrate to your medical insurance provider your prosthetic requirements.

Vocation: _____ Self-Employed: ☐ YES ☐ NO

Name and address of the company you work for:

_____

_____

_____

_____

Average hours worked / week: _____

Average weeks worked / month: _____

Average months worked / year: _____

Please generally describe your primary place of work: (i.e. loading docks, professional office building, construction site, etc.)

_____

_____

If you work in different predetermined locations, please state the other addresses and provide a brief description:

_____

_____

_____

Please describe the type of environment you work in: (i.e. indoors climate controlled, outdoors in rain and temperatures between 32 - 99 F, etc.)

_____

_____

_____

Please list the types of surfaces you commonly work on or around: (i.e. dirt, fields, ice, carpet, wet surfaces, concrete, steps, ramps, etc.)

_____

_____

_____