CREATIVE PROSTHETICS & ORTHOTICS, LLC
ORTHOTIC/PROSTHETIC EVALUATION

PATIENT NAME: _____

DATE OF EVALUATION: _____ ☐ NEW RX PRESENTED ☐ NO RX PRESENTED

Are you ambulatory: ☐ Yes ☐ No

Is this the FIRST device of this kind you have received? ☐ Yes ☐ No If No, please answer the following questions. If Yes, please sign form and give to office staff.

Is the device you are currently wearing the last device you have received? ☐ Yes ☐ No

On what date did you receive your most recent device? _____

What company provided your most recent device?

_____

Company Name

_____

Street address City State Zip

Why is your current device not acceptable to you at this time? _____

_____

Is your current device ☐ Too big ☐ Too small ☐ Just worn out

Have you **gained** weight since you received your last device? ☐ Yes ☐ No
If yes, how much weight have you gained? _____

Have you **lost** weight since you received your last device? ☐ Yes ☐ No
If yes, how much weight have you lost? _____

Has your condition worsened/changed since you received your last device? ☐ Yes ☐ No
If yes, please explain _____

_____

On what date did your physician last examine you FOR THE DEVICE YOU ARE WEARING? _____

_____

Patient Signature