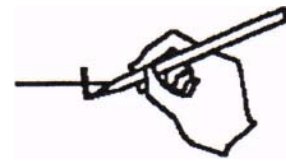


Study Number _____
Date _____

Prosthesis Evaluation Questionnaire



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Seattle, WA, USA

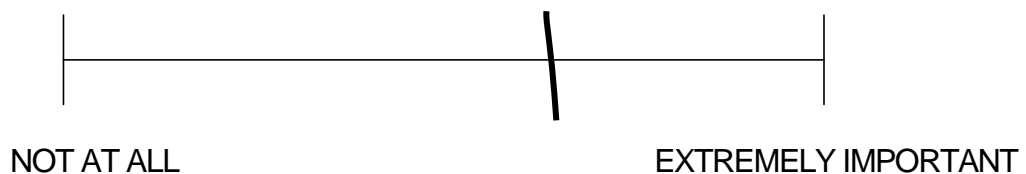
Instructions

As you read each question, remember there is no right or wrong answer. Just think of YOUR OWN OPINION on the topic and make a mark THROUGH the line anywhere along the line from one end to the other to show us your opinion.

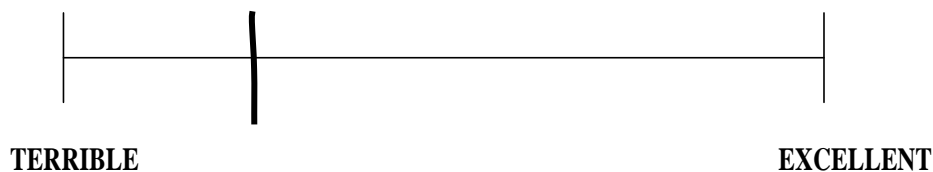
If you use different prostheses for different activities, please choose the ONE you use more often and answer all the questions as though you were using that prosthesis.

Example

How important is it to you to have coffee in the morning?



Over the past four weeks, rate your morning coffee.

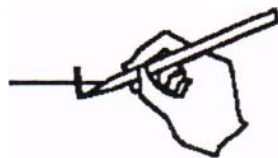


OR check I haven't drunk coffee in the morning in the past four weeks.

This example shows that the person who answered these questions feels that having coffee in the morning is important to him. He also thinks the coffee he has had lately has not been very good.

If he hadn't drunk any coffee in the last four weeks, he would have put a check by that statement instead of putting a mark on the line between TERRIBLE and EXCELLENT.

As in this example, make a mark across the line rather than using an X or an O.



Please answer all the questions.

Support for development of the PEQ was provided by the U.S. Department of Veterans Affairs.

Group 1

These first questions are about YOUR PROSTHESIS.

A. Over the past four weeks, rate how happy you have been with your current prosthesis.

EXTREMELY UNHAPPY

EXTREMELY HAPPY

B. Over the past four weeks, rate the fit of your prosthesis.

TERRIBLE

EXCELLENT

C. Over the past four weeks, rate the weight of your prosthesis.

TERRIBLE

EXCELLENT

D. Over the past four weeks, rate your comfort while standing *when using your prosthesis*.

TERRIBLE

EXCELLENT

E. Over the past four weeks, rate your comfort while sitting *when using your prosthesis*.

TERRIBLE EXCELLENT

F. Over the past four weeks, rate how often you felt off balance *while using your prosthesis*.

ALL THE TIME NOT AT ALL

G. Over the past four weeks, rate how much energy it took to use your prosthesis for as long as you needed it.

COMPLETELY EXHAUSTING NONE AT ALL

H. Over the past four weeks, rate the feel (such as the temperature and texture) of the prosthesis (sock, liner, socket) on your residual limb (stump).

WORST POSSIBLE BEST POSSIBLE

I. Over the past four weeks, rate the ease of putting on (donning) your prosthesis.

TERRIBLE EXCELLENT

J. Over the past four weeks, rate how your prosthesis has looked.

TERRIBLE EXCELLENT

K. Over the past four weeks, rate how often your prosthesis made squeaking, clicking, or belching sounds.

ALWAYS NEVER

L. If it made any sounds in the past four weeks, rate how bothersome these sounds were to you.

EXTREMELY BOTHERSOME NOT AT ALL

OR check ___ It made no sounds.

M. Over the past four weeks, rate the damage done to your clothing by your prosthesis.

EXTENSIVE DAMAGE NONE

N. Over the past four weeks, rate the damage done to your prosthesis cover.

EXTENSIVE DAMAGE NONE

OR check ___ There is no cover on my prosthesis.

O. Over the past four weeks, rate your ability to wear the shoes (different heights, styles) you prefer.

CANNOT NO PROBLEM

P. Over the past four weeks, rate how limited your choice of clothing was because of your prosthesis.

WORST POSSIBLE NOT AT ALL

Q. Over the past four weeks, rate how much you sweat inside your prosthesis (in the sock, liner, socket).

EXTREME AMOUNT NOT AT ALL

R. Over the past four weeks, rate how smelly your prosthesis was at its worst.

EXTREMELY SMELLY NOT AT ALL

S. Over the past four weeks, rate how much of the time your residual limb was swollen to the point of changing the fit of your prosthesis.

ALL THE TIME NEVER

T. Over the past four weeks, rate any rash(es) that you got on your residual limb.

EXTREMELY BOTHERSOME NOT AT ALL

OR check ___ I had no rashes on my residual limb in the last month.

U. Over the past four weeks, rate any ingrown hairs (pimples) that were on your residual limb.

EXTREMELY BOTHERSOME NOT AT ALL

OR check ___ I had no ingrown hairs on my residual limb in the last month.

V. Over the past four weeks, rate any blisters or sores that you got on your residual limb.

EXTREMELY BOTHERSOME NOT AT ALL

OR check ___ I had no blisters or sores on my residual limb in the last month.

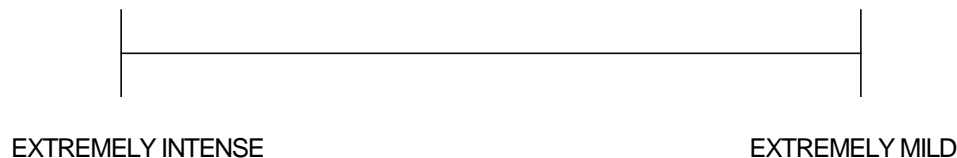
Group 2

The next section covers very *SPECIFIC BODILY SENSATIONS*. Here are our definitions:

1. *SENSATIONS* are feelings like "pressure", "tickle" or a sense of position or location, such as the toes being curled. Amputees have described sensations in their missing (phantom) limb such as "the feeling that my (missing) foot is wrapped in cotton."
2. *PAIN* is a more extreme sensation described by terms such as "shooting", "searing", "stabbing", "sharp", or "ache".
3. *PHANTOM LIMB* refers to the part that is missing. People have reported feeling sensations and/or pain in the part of the limb that has been amputated — that is, in their phantom limb.
4. *RESIDUAL LIMB (STUMP)* refers to the portion of your amputated limb that is still physically present.

REGARDING SENSATIONS IN YOUR PHANTOM LIMB

- A. Over the past four weeks, rate how often you have been aware of non-painful sensations in your phantom limb.
- a. ___ never
 - b. ___ only once or twice
 - c. ___ a few times (about once/week)
 - d. ___ fairly often (2-3 times/week)
 - e. ___ very often (4-6 times/week)
 - f. ___ several times every day
 - g. ___ all the time or almost all the time
- B. If you had non-painful sensations in your phantom limb during the past month, rate how intense they were on average.



OR check ___ I did not have non-painful sensations in my phantom limb.

- C. Over the past month, how bothersome were these sensations in your phantom limb?



OR check ___ I did not have non-painful sensations in my phantom limb.

REGARDING PAIN IN YOUR PHANTOM LIMB

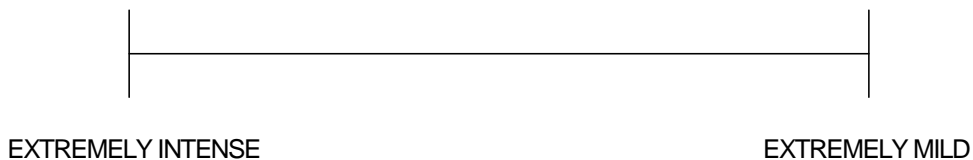
D. Over the past four weeks, rate how often you had pain in your phantom limb.

- a. never
- b. only once or twice
- c. a few times (about once/week)
- d. fairly often (2-3 times/week)
- e. very often (4-6 times/week)
- f. several times every day
- g. all the time or almost all the time

E. How long does your phantom limb pain usually last?

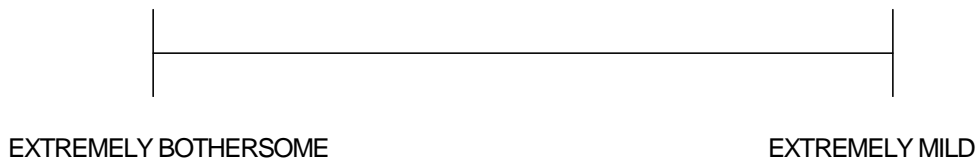
- a. I have none
- b. a few seconds
- c. a few minutes
- d. several minutes to an hour
- e. several hours
- f. a day or two
- g. more than two days

F. If you had any pain in your phantom limb this past month, rate how intense it was on average.



OR check I did not have any pain in my phantom limb.

G. In the past four weeks how bothersome was the pain in your phantom limb?



OR check I did not have any pain in my phantom limb.

REGARDING PAIN IN YOUR RESIDUAL LIMB (STUMP)

H. Over the past four weeks, rate how often you had pain in your residual limb.

- a. ___ never
- b. ___ only once or twice
- c. ___ a few times (about once/week)
- d. ___ fairly often (2-3 times/week)
- e. ___ very often (4-6 times/week)
- f. ___ several times every day
- g. ___ all the time or almost all the time

I. If you had any pain in your residual limb over the past four weeks, rate how intense it was on average.



OR check ___ I did not have any pain in my residual limb.

J. OVER THE past four weeks how bothersome was the pain in your residual limb?



OR check ___ I did not have any pain in my residual limb.

REGARDING PAIN IN YOUR OTHER (NON-AMPUTATED) LEG OR FOOT

K. Over the past four weeks, rate how often you had pain in your other leg or foot.

- a. ___ never
- b. ___ only once or twice
- c. ___ a few times (about once/week)
- d. ___ fairly often (2-3 times/week)
- e. ___ very often (4-6 times/week)
- f. ___ several times every day
- g. ___ all the time or almost all the time

L. If you had any pain in your other leg or foot over the past four weeks, rate how intense it was on average.

EXTREMELY INTENSE EXTREMELY MILD

OR check ___ I had no pain in my other leg or foot.

M. OVER THE past four weeks how bothersome was the pain in your other leg or foot?

EXTREMELY BOTHERSOME NOT AT ALL

OR check ___ I had no pain in my other leg or foot.

REGARDING BACK PAIN

N. Over the past four weeks, rate how often you experienced back pain.

- a. ___ never
- b. ___ only once or twice
- c. ___ a few times (about once/week)
- d. ___ fairly often (2-3 times/week)
- e. ___ very often (4-6 times/week)
- f. ___ several times every day
- g. ___ all the time or almost all the time

O. If you had any back pain over the past four weeks, rate how intense it was on average.

EXTREMELY INTENSE EXTREMELY MILD

OR check ___ I had no back pain.

P. OVER THE past four weeks how bothersome was the back pain?

EXTREMELY BOTHERSOME NOT AT ALL

OR check ___ I had no back pain.

Group 3

This section is about some of the SOCIAL AND EMOTIONAL ASPECTS OF USING A PROSTHESIS.

A. Over the past four weeks, rate how often the desire to avoid strangers' reactions to your prosthesis made you avoid doing something you otherwise would have done.

ALL THE TIME NEVER

B. Over the past four weeks, rate how frequently you were frustrated with your prosthesis.

ALL THE TIME NEVER

C. If you were frustrated with your prosthesis at any time over the past month, think of the most frustrating event and rate how you felt at that time.

EXTREMELY FRUSTRATED NOT AT ALL

OR check ___ I have not been frustrated with my prosthesis.

We understand that sometimes you will have both positive and negative experiences with those close to you. Please try to answer these questions considering all the reactions you have had.

D. Over the past four weeks, rate how your partner has responded to your prosthesis

VERY POORLY VERY WELL

OR check I don't have a partner.

E. Over the past four weeks, rate how this response has affected your relationship.

VERY BADLY VERY WELL

OR check I don't have a partner.

F. Think of two close family members (other than your partner) and write down their relationship to you, like mother or son.

#1 _____ #2 _____

OR check I don't have any close family members.

G. Over the past four weeks, rate how Family Member #1 has responded to your prosthesis

VERY POORLY VERY WELL

OR check I don't have close family members.

H. Over the past four weeks, rate how Family Member #2 has responded to your prosthesis.

VERY POORLY VERY WELL

OR check ___ I don't have a second close family member.

I. Over the past four weeks, rate how much a burden your prosthesis has been on your partner or family members.

EXTREMELY BURDENSOME NOT AT ALL

OR check ___ I don't have a partner or family members.

J. Over the past four weeks, rate how much having your prosthesis has hindered you socially.

A GREAT DEAL NOT AT ALL

K. Over the past four weeks, rate your ability to take care of someone else, (e.g. your partner, a child, or a friend).

CANNOT NO PROBLEM

OR check ___ I don't take care of someone else.

Group 4

This section is about YOUR ABILITY TO MOVE AROUND.

- A. Over the past four weeks, rate your ability to walk *when using your prosthesis*.**

CANNOT NO PROBLEM

- B. Over the past four weeks, rate your ability to walk in close spaces *when using your prosthesis*.**

CANNOT NO PROBLEM

- C. Over the past four weeks, rate your ability to walk up stairs *when using your prosthesis*.**

CANNOT NO PROBLEM

- D. Over the past four weeks, rate how you have felt about being able to walk down stairs *when using your prosthesis*.**

CANNOT NO PROBLEM

E. Over the past four weeks, rate your ability to walk up a steep hill *when using your prosthesis*.

CANNOT NO PROBLEM

F. Over the past four weeks, rate your ability to walk down a steep hill *when using your prosthesis*.

CANNOT NO PROBLEM

G. Over the past four weeks, rate your ability to walk on sidewalks and streets *when using your prosthesis*.

CANNOT NO PROBLEM

H. Over the past four weeks, rate your ability to walk on slippery surfaces (e.g. wet tile, snow, a rainy street, or a boat deck) *when using your prosthesis*.

CANNOT NO PROBLEM

I. Over the past four weeks, rate your ability to get in and out of a car *when using your prosthesis*.

CANNOT NO PROBLEM

J. Over the past four weeks, rate your ability to sit down and get up from a chair with a high seat (e.g., a dining chair, a kitchen chair, an office chair).

CANNOT NO PROBLEM

K. Over the past four weeks, rate your ability to sit down and get up from a low or soft chair (e.g. an easy chair or deep sofa).

CANNOT NO PROBLEM

L. Over the past four weeks, rate your ability to sit down and get up from the toilet.

CANNOT NO PROBLEM

M. Over the past four weeks, rate your ability to shower or bathe safely.

CANNOT NO PROBLEM

E. How satisfied are you with the person who fit your current prosthesis?

EXTREMELY DISSATISFIED EXTREMELY SATISFIED

F. How satisfied are you with the training you have received on using your current prosthesis?

EXTREMELY DISSATISFIED EXTREMELY SATISFIED

OR check _ I have not had any training with my current prosthesis.

G. Overall, how satisfied are you with the gait and prosthetic training you have received since your amputation.

EXTREMELY DISSATISFIED EXTREMELY SATISFIED

OR check _ I have not had any training since my amputation.

Group 6

This next section asks you to rate your ability TO DO YOUR DAILY ACTIVITIES when you are having problems with your prosthesis.

A. When the fit of my prosthesis is poor, I will get...



NOTHING DONE EVERYTHING DONE

B. When the comfort of my prosthesis is poor, I will get...



NOTHING DONE EVERYTHING DONE

C. Without my prosthesis, I will get...



NOTHING DONE EVERYTHING DONE

Group 7

This last section asks you to rate HOW IMPORTANT different aspects (or qualities) of your prosthesis are to you.

A. How important is it that the weight of your prosthesis feel right?



NOT AT ALL EXTREMELY IMPORTANT

B. How important is the ease of putting on (donning) your prosthesis?

NOT AT ALL EXTREMELY IMPORTANT

C. How important is the appearance of your prosthesis (how it looks)?

NOT AT ALL EXTREMELY IMPORTANT

D. How important is it to you to be able to wear different kinds of shoes (heights or styles)?

NOT AT ALL EXTREMELY IMPORTANT

E. How important is it that your prosthesis' covering is durable (cannot be torn, dented, easily scratched, or discolored)?

NOT AT ALL EXTREMELY IMPORTANT

OR check There is no covering on my prosthesis.

F. How bothersome is it when you sweat a lot inside your prosthesis (in the sock, liner, socket)?

EXTREMELY BOTHERSOME NOT AT ALL

G. How bothersome to you is swelling in your residual limb (stump)?

EXTREMELY BOTHERSOME NOT AT ALL

H. How important is it to avoid having any ingrown hairs (pimples) on your residual limb (stump)?

NOT AT ALL EXTREMELY IMPORTANT

I. How bothersome is it to see people looking at you and your prosthesis?

EXTREMELY BOTHERSOME NOT AT ALL

J. How important is being able to walk up a steep hill?

NOT AT ALL EXTREMELY IMPORTANT

Final Notes

A. If any of the following have happened in the past four weeks, please check off and give a brief description:

___ a serious medical problem (yours)

___ a noticeable change in pain

___ a serious personal problem (yours)

___ a serious problem in the family

___ some other big change has occurred in your life

If you checked any of the five previous items, please give a brief description.

B. Please share with us anything else about you or your prosthesis that you think would be helpful for us to know (continue on the back of this page if you need more space).

THANK YOU VERY MUCH!

Acknowledgement: Roorda LD, Roebroek ME, Lankhorst GJ, van Tilburg T, Bouter LM. Measuring functional limitations in rising and sitting down: Development of a questionnaire. Arch Phys Med Rehabil 1996;77:663-669 for their influence on questions 4-J, 4-K, and 4-L.