

# Pre-screening form

This is a form for you who are interested in participating in our research on the surgical treatment of pain after amputation. In this form, we ask you to answer relevant questions regarding your situation. We expect it to take approximately 5 minutes to complete.

By submitting the form, you agree that your data will be stored and used exclusively by relevant staff in the research group. The information will only be used for the purpose of determining eligibility to participate in the research conducted by the group.

## Contact information

**Name**

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**Mobile phone**

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**Email**

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**City**

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## Amputation

**Date of amputation**

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**Amputation cause**

*Ex. trauma, cancer, diabetes,  
or other reasons*

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**Amputation level**

*Ex. transfemoral amputation*

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**Residual limb length**

*Ex. 10 cm*

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 cm

## Prosthetic use

**Do you use a prosthesis?**   ☐ Yes   ☐ No

If Yes, continue with next question, if No go to the last question on the page.

**Type of prosthesis**   ☐ Passive   ☐ Myoelectric   ☐ Other

If other, what type:

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**How often do you use your prosthesis?**

- ☐ More than 12 hours per day
- ☐ Couple of hours per day
- ☐ One time during the day
- ☐ Couple of hours per week
- ☐ Couple of times per month
- ☐ Never

**How satisfied are you with your prosthesis?**

☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐  
0   1   2   3   4   5   6   7   8   9   10

Not at all satisfied

Fully satisfied

**When was your last prosthetic fitting?**

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**Why don't you use a prosthesis?**

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## Pain

**What type of pain do you experience?**

☐ Residual limb pain    ☐ Phantom limb pain

**What is the maximum pain intensity you have experienced?**

☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐  
0   1   2   3   4   5   6   7   8   9   10

No pain

Unbearable pain

**What is the average pain intensity you have experienced in the last two weeks?**

☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐  
0   1   2   3   4   5   6   7   8   9   10

No pain

Unbearable pain

**How often do you experience pain?**

- ☐ Constantly
- ☐ Couple of hours per day
- ☐ Couple of times during the day
- ☐ Couple of times during the week
- ☐ Couple of times during the month
- ☐ Never

**Which pain treatments have you previously received?**

*Fill in all the treatments you have previously tried.*

- ☐ Talk therapy
- ☐ AR or VR
- ☐ TENS
- ☐ Painkillers
- ☐ Physical activity
- ☐ Other treatments

If others, which: \_\_\_\_\_

## General health

**Do you smoke?** ☐ Yes ☐ No

**Do you have high blood pressure?** ☐ Yes ☐ No

**Do you have diabetes?** ☐ Yes ☐ No

## Other questions

**Do you participate in another clinical study?** ☐ Yes ☐ No

If yes, which type of study: \_\_\_\_\_

**Is there something else you want us to know?**