PATIENT NAME_____
PATIENT ID # _____

ASSESSMENT FORM

Name: _____ Sex: M ☐ F ☐ DOB: _____

Address: _____ Phone No.: _____

Therapist: _____ Agency: _____

Wheelchair being considered: Manual ☐ Elec. ☐ _____ Assessment Date: _____

People consulted: _____

MEDICAL HISTORY

Diagnosis/Onset: _____

_____ ☐ Stable ☐ Detoriating

Past Surgeries: ☐ Bone ☐ Skin ☐ Muscle ☐ Other _____

Orthotics/Prosthetics: _____

Medications: _____

Medical Doctor: _____ Ph: _____

Health Professional(s): _____ Ph: _____

SOCIAL HISTORY

Lives alone ☐ Spouse ☐ Other Family ☐ Friend ☐ Other ☐ _____

Primary Carer details: (eg general health, agency contact) _____

Accomodation: Home/Unit ☐ Retirement Village ☐ Condo ☐ Other ☐ _____

Ownership: Owner ☐ Rents ☐ Other ☐ _____

Primary Living/Work Environment : (note accessibility, etc.) _____

_____

Narrowest Doorway: _____ Type of setting: ☐ Rural ☐ Suburban ☐ Urban

☐ Sidewalks ☐ Paved Roads ☐ Rough Terrain _____

Other locations where w/c will be used: _____

_____ Intends to use at night: ☐ Yes ☐ No

Transportation : ☐ Car (passenger) ☐ Car (driver) ☐ Van ☐ Bus ☐ Taxi ☐ Other _____

Details: _____

FUNCTIONAL STATUS

Transfers: ☐ Hoist ☐ Standing pivot ☐ Non-standing pivot ☐ Pull to stand ☐ Push to stand ☐ Sliding

☐ Other: _____ Details/Assistance: _____

_____ Observed: ☐ Yes ☐ No

Ambulation status: (note device used) _____

Wheelchair Use: Independent ☐ Assisted ☐ Dependent ☐ _____ Hours/Day: _____

PATIENT NAME_____
PATIENT ID # _____

FUNCTIONAL STATUS (continued)

Eating/Meal Preparation: _____

Communication: (writing/telephone/computer) _____

Dressing/Grooming: _____

Bed Mobility: _____ Bed hgt: _____

Toiletting: Bladder: ☐ Continent ☐ Odd accident ☐ Incontinent ☐ Catheterised ☐ Intermittent catheter

Bowel: ☐ Continent ☐ Odd accident ☐ Incontinent

Equipment: _____

Transfers: _____ Seat hgt: _____

Comments: _____

Other Daily Activities, eg sport: _____

PHYSICAL EVALUATION

Visual Hx/Aids : _____

Visual Scanning/Acuity/Fields : ☐ Intact ☐ Impaired Comments: _____

_____

Hearing : ☐ Normal ☐ Impaired ☐ Deaf _____

Communication : ☐ Verbal ☐ Non-verbal Method: _____

Cognition & Perception : _____

_____

Respiration : ☐ Normal ☐ Vent. dependent ☐ 02 dependent ☐ Hx of chronic congestions

Equipment: (eg ventilator, battery, O2 cylinder, suction machine) _____

Dimensions: _____ Weight: _____

Sensation : (note areas that are abnormal or insensate) _____

_____

Skin Integrity : ☐ Intact ☐ Hx of Sores ☐ Red Area ☐ Open Area ☐ Scar Tissue

at risk from: ☐ Orthotics ☐ Prolonged Sitting ☐ Poor Skin Condition ☐ Moisture ☐ Other

Comments: _____

Skin Inspection: ☐ Independent ☐ Assisted ☐ Dependent

Method: _____

Pressure Relief: ☐ Independent ☐ Assisted ☐ Dependent

Method: _____

Upper Limb Function: (note coordination & strength) _____

_____ R handed ☐ L handed ☐

Lower Limb Function: (note amputation etc.) _____

_____

PATIENT NAME_____
PATIENT ID # _____

CURRENT SEATED POSITION (as best evaluated – note fixed positions)

Balance/Trunk Control: _____

Head: ☐ Neutral ☐ Hyperextended ☐ Fwd flexed ☐ Laterally flexed: ☐ R ☐ L ☐ Rotated: ☐R ☐L

Shoulders: ☐ Level ☐ Elevated: ☐R ☐L ☐ Sublaxed: ☐R ☐L

Rib Cage: ☐ Neutral ☐ Elevated: ☐ R ☐ L ☐ Rotated fwd: ☐ R ☐ L

Spine: ☐ Neutral ☐ Scoliosis, apex on : ☐R ☐ L ☐ Kyphosis: _____

☐ Normal lumbar space ☐ Flat Lumbar Space ☐ Hyper-lordotic

Pelvis: ☐ Neutral ☐ Posterior Tilt ☐ Anterior Tilt ☐ Rotated fwd: ☐R ☐L

☐ Oblique, lower: ☐R ☐L ☐ Other: _____

Hips: ☐ Flexed: ☐ R ☐L ☐ Extended: ☐ R ☐ L ☐ Abducted: ☐R ☐ L ☐ Adducted: ☐R ☐ L

Knees: ☐ Flexed (beyond 90º): ☐R ☐L ☐ Extended (beyond 90º): ☐R ☐L

Feet: ☐ Dorsiflexed: ☐R ☐L ☐ Plantarflexed: ☐R ☐L ☐ Supinate/Inv: ☐R ☐L

☐ Pronate/Evert: ☐ R ☐L Other: _____

Spasticity/ Reflexes/Tone: _____

_____

Comments: _____

_____

_____

WHEELCHAIR HISTORY

1. ☐ Manual ☐ Elec. Model: _____ Period of use: _____

Frame ☐ Folding ☐ Rigid Armrest Hgt: _____ Hanger length: _____

Seat Depth: _____ Width: _____ Hgt (front): _____ Hgt (back): _____

Other measurements: _____

Accessories/Features: _____

Issues: _____

Hx of accidents/collisions: _____

2. ☐ Manual ☐ Elec. Model: _____ Period of use: _____

Frame ☐ Folding ☐ Rigid Armrest Hgt: _____ Hanger length: _____

Seat Depth: _____ Width: _____ Hgt (front): _____ Hgt (back): _____

Other measurements: _____

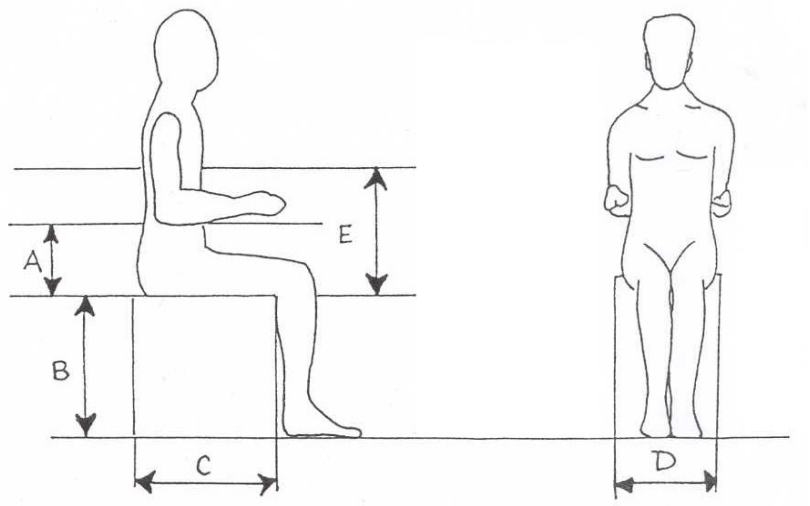
Accessories/Features: _____

Issues: _____

Hx of accidents/collisions: _____

PATIENT NAME_____
PATIENT ID # _____

BASIC DIMENSIONS



A Seat to elbow: _____

B Back of knee to heel: _____

C Posterior of buttocks to back of knee: _____

D Widest point at hips or thighs: _____

E Seat to base of scapula: _____

Height: _____ Weight: _____

CLIENT GOALS & CONCERNS

_____

_____

_____

_____

ADDITIONAL NOTES / SUMMARY

_____

_____

_____

_____

_____

_____

_____

_____

Short Term Plan (s): ☐ Mat Evaluation Date/Place: _____

☐ Trial Equipment : _____

Date/Place: _____

☐ Obtain Medical Clearance from Doctor

☐ Obtain further info. _____

☐ Other: _____

Therapist's Signature: _____ Date: _____

Therapist's Name: _____

WHEELCHAIR SPECIFICATION

Client's Name: _____ Sex: M ☐ F ☐ DOB: _____

Wheelchair Brand: _____

Frame:

Rear Wheels:

_____

Front Wheels:

_____

Brakes:

_____

Axles/Axle Plate:

_____

Push Handles:

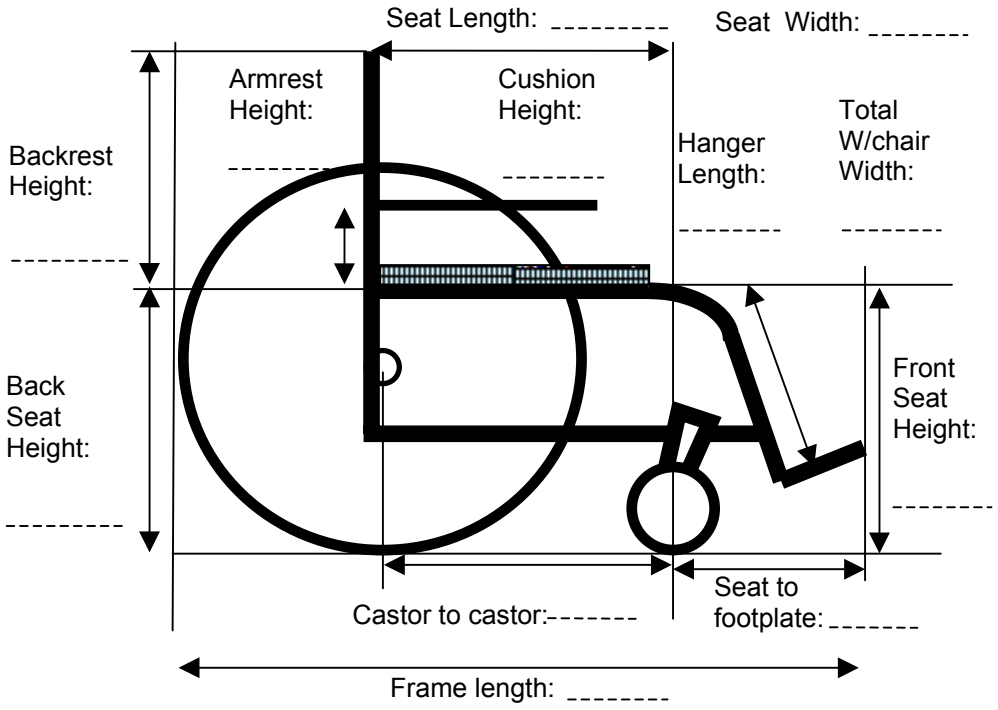
_____

Armrests:

_____

Footplates/Legrests:

_____



Upholstery/Seating : _____

Options:

☐ Headrest	☐ Anti-tip bar & roller	☐ Tilting bars
☐ Carry bag	☐ Oxygen bottle carrier	☐ Tray
☐ Stump support	☐ IV pole	☐ Straps/belts
☐ Clothes Guards	☐ Tilt in space: manual / electric	☐ Recline: manual / electric
☐ Others: _____		

Details: _____

ADDITIONAL NOTES:

Therapist's Signature: _____ Date: _____

Therapist's Name: _____