# Seating Wheeled Mobility Clinic
# Pre Appointment Questionnaire

Client's Name _____

1. Does the person presently have a wheelchair or scooter? Yes ____ No ____
    a. If yes:
        i. Manufacturer: _____
        ii. Model: _____ Vendor: _____ Year: _____
        iii. Year received: _____ Funding Source: _____
        iv. Describe system:

            _____

            _____
    b. If no:
        i. What is the person's mobility: Describe:

            _____

            _____
2. Is the person **functional** in a seated position? Yes ____ No ____ Describe:

    _____

    _____
3. Is the person **comfortable** in a seated position? Yes ____ No ____ Describe:

    _____

    _____
4. Has the person had any incidents of pressure/skin problems due to seated position? Yes ____ No ____ Describe: _____

    _____

    _____
5. Does the person perform weight shifts independently or require another person's assistance? (CIRCLE ONE) Independently Requires Assistance
6. Please list any specific features which you feel should be incorporated into a new/modified seating system:

    _____

    _____

 

7. Situations in which the system is being or will be used (Check all that apply)
   - _ Home
   - _ School
   - _ Prevocational Program
   - _ Day Program
   - _ Bus Transportation
   - _ Recreational Activity (Specify) _____
   - _ Other (Specify) _____
   - _ Grass
   - _ Gravel
   - _ Pavement
   - _ Sidewalks
   - _ Tile
   - _ Thick Carpet

8. How will this system be transported?
   a. Public transport ____
   b. Private/Family vehicle ___
      i. Vehicle Type _____ Model _____
      ii. 2 door __ 4 door__
      iii. Van opening height ____ width ____
   c. Storage Place: trunk ___ backseat ___ used as car seat ___ other _____
      Bus ___ Van ___ Power lift ___ Ramp ___ Lift by person ___
   d. Wheelchair securement system: Tie down system ___ Docking system ___ Other ___
9. What type of transfers are currently used? (Check all that apply)
   - _ Standing
   - _ Transfer board
   - _ Hoyer lift
   - _ Maximum assist lift
   - _ Squat pivot transfer
   - _ Pop over transfer
   - _ Other _____
10. How much assistance is needed with transfers?
   - _ Independent
   - _ Minimal assist
   - _ Moderate assist
   - _ Maximal assist
   - _ Two person assist
   - _ Mechanical assist
11. Does the person participate in (check all that apply)
   - _ Table top activities Specify table heights _____
   - _ Lap tray activities
   - _ Standing activities (describe device i.e. prone stander, at table side, counter, walker, etc.) _____
   - _ Other _____
12. How many hours does the person spend in the wheelchair daily?
    _____ hrs (continuously ___ or on/off ____)

13. List other equipment/furniture used during the day: (Check all that apply)
    - _ Wheelchair (manual)
    - _ Wheelchair (power)
    - _ Scooter
    - _ Stander
    - _ Sidelyer
    - _ Walker
    - _ Sofa
    - _ Reclining chair
    - _ Chair at table
    - _ Cane
    - _ Crutches
    - _ Other/Specify
14. What other special equipment needs to be mounted to the wheelchair or scooter- please specify present location (check all that apply)
    - _ Oxygen
    - _ Suction
    - _ Ventilator
    - _ Augmentative communication
    - _ Crutch holder
    - _ Other _____
15. Do you feel the person's growth rate is normal or below normal for age?
    Normal ___ Below Normal ___
16. Has the person's weight been stable in the last 6 months? Weight _____ pounds
    Yes ___ No ___ Pounds (Gained ___ Lost ___)
17. Does the person have any visual or hearing limitations?
    Yes ___ No ___ Specify _____
18. Arm Usage (Check appropriate choice)
    - _ Has full use of both arms
    - _ Has use of one hand only
    - _ Unable to use arms ___ hands ___ both ___
    - _ Partial use of arms ___ Describe _____
19. Does the person use any of the following (Check all that apply)
    - _ Splints
    - _ Braces
    - _ Artificial limb(s)
    - _ Glasses
    - _ Hearing aids
    - _ Other (Specify)
20. Home Specifications:
    Door opening widths: Usual Entrance _____ Bathroom _____ Person's bedroom _____
21. Does your approach/entrance to your home include: (Check all that apply)
    - _ Sidewalk
    - _ Steps - Number of steps ____ Height: _____ Width: ____
    - _ Ramp - Length: _____ Width: _____
    - _ Threshold - Height: ____
22. Please draw a floor plan of the home bathroom which the person uses, including locations of sink, toilet, tub/shower and attach it to this form (Use back of last page)

 

23. How does the person use the bathroom? (Check all that apply)

_ Toilet
_ Bedside commode
_ Urinal
_ Commode chair
_ Catheter
_ Diapers
_ Other: _____

24. Are there physical limitations on the part of the caregiver(s)? Yes ____ No ____ Describe:

_____

_____

**25.** Please indicate the frequency of any of the following therapy and support services this person is currently receiving:

| | **Frequency** | **Therapist/Staff** |
|---|---|---|
| Direct speech/language therapy | _____ | _____ |
| Consultative speech/language therapy | _____ | _____ |
| Direct physical therapy | _____ | _____ |
| Consultative physical therapy | _____ | _____ |
| Direct occupational therapy | _____ | _____ |
| Resource room | _____ | _____ |
| Consultative occupational therapy | _____ | _____ |
| Psychological/Counseling services | _____ | _____ |
| Auditory Training | _____ | _____ |
| Vocational rehab training | _____ | _____ |
| Pre-vocational rehab training | _____ | _____ |
| College readiness training | _____ | _____ |
| Independent living training | _____ | _____ |
| Driving training | _____ | _____ |
| Home health services | _____ | _____ |
| Skilled nursing services | _____ | _____ |
| Wound care services | _____ | _____ |
| Pain clinic services | _____ | _____ |
| Personal Care Assistance services | _____ | _____ |

Return form by _____ to:

 Revised: 12/12/2014 