CLIENT ASSESSMENT
FOR SEATING & MOBILITY

CLIENT NAME: _____ **Date of Onset:** _____

Current Wheelchair

☐ None ☐ Power Wheelchair ☐ Scooter ☐ Manual Wheelchair

Date Purchased/Rented (mm/yy): _____/_____ Paid for by: _____

Supplier: _____ Make: _____

Serial #: _____ Information Provided By: _____

Height: _____ Weight: _____ Diagnosis: _____

Does client use any other assistive technology devices?

☐ None ☐ Walker ☐ Cane ☐ Crutches

☐ Prosthesis ☐ Lift Chair ☐ Stander ☐ Orthotics/ Braces

☐ Other: *(describe)* _____

Is this a replacement wheelchair (wc)? ☐ YES ☐ NO

If yes, reason wheelchair needs to be replaced:

☐ Worn beyond repair ☐ Too small due to growth ☐ Too small due to weight gain

☐ Unable to accommodate manual tilt ☐ Unable to accommodate power seating ☐ Unable to propel manual wc

☐ Unable to accommodate seating system ☐ Other: *(describe)* _____

Wheelchair (wc) Propulsion

☐ Requires manual wc for independent mobility

☐ Unable to self propel manual wc, requires manual wc for dependent mobility

☐ Low seat-to-floor height needed to foot propel

☐ Unable to propel standard or lightweight manual wc; requires high strength light weight wc for ind. mobility

☐ Requires manual wc as a back up mobility to power wc

☐ Unable to propel manual wc; requires power mobility

Ambulation

☐ Unable to ambulate

☐ Ambulates with assistance

Type of assistance: _____

Distance able to ambulate: _____

Poor balance? ☐ YES ☐ NO

History with falls? ☐ YES ☐ NO

Injuries with falls? ☐ YES ☐ NO

Transfer style

☐ Stand pivot ☐ Sliding board ☐ Lateral transfer ☐ 1 or 2 person lift ☐ Patient lifter

Assistance required

☐ Independent ☐ Requires Assistance ☐ Dependent

Home Environment

☐ Single family home ☐ Apartment ☐ Nursing home ☐ Independent living facility

☐ Mobile home ☐ Group home ☐ Retirement facility

The client's home environment can be accessed by the ordered equipment? ☐ YES ☐ NO ☐ PENDING (explain in comments section)

Client Resides With:

☐ Alone, No Caregiver ☐ Children ☐ Family

☐ Spouse ☐ Alone, Caregiver Assist ☐ Facility, Caregiver Assist

☐ Other: _____

Mobility Related Activities of Daily Living (MRADL)

Is a mobility device required to allow client to complete MRADL in their home environment?

☐ YES ☐ NO

Is client at risk for injury while attempting to walk in home to complete MRADLs in a reasonable amount of time?

☐ YES ☐ NO ☐ NA (client is non-ambulatory)

CLIENT NAME: _____

Physical Limitations *(check all that apply)*

LIMITED PURPOSEFUL MOVEMENT:

- ☐ All extremities
- ☐ Bilateral lower extremities
- ☐ Bilateral upper extremities
- ☐ Right lower extremities
- ☐ Left lower extremities
- ☐ Right upper extremities
- ☐ Left upper extremities
- ☐ N/A

PARALYSIS OF:

- ☐ All extremities
- ☐ Bilateral lower extremities
- ☐ Bilateral upper extremities
- ☐ Right lower extremities
- ☐ Left lower extremities
- ☐ Right upper extremities
- ☐ Left upper extremities
- ☐ N/A

WEAKNESS OF:

- ☐ All extremities
- ☐ Bilateral lower extremities
- ☐ Bilateral upper extremities
- ☐ Right lower extremities
- ☐ Left lower extremities
- ☐ Right upper extremities
- ☐ Left upper extremities
- ☐ N/A

SPASTICITY OF:

- ☐ All extremities
- ☐ Bilateral lower extremities
- ☐ Bilateral upper extremities
- ☐ Right lower extremities
- ☐ Left lower extremities
- ☐ Right upper extremities
- ☐ Left upper extremities
- ☐ N/A

Severely limited endurance?	☐ YES	☐ NO
Oxygen dependent?	☐ YES	☐ NO
Hypoxia (SOB) with exertion?	☐ YES	☐ NO
Lower extemities edema?	☐ YES	☐ NO

Power Mobility Device (PMD) Assessment

If a power wheelchair is being provided, explain why client cannot use a scooter:

- ☐ Home environment is too small
- ☐ Upper extremities are too weak to operate tiller
- ☐ Poor trunk control
- ☐ Client requires seating not available on scooter
- ☐ Client cannot safely transfer on/off scooter
- ☐ Other: *(explain)* _____

_____

_____

Visual, perceptual and motor skills allow for safe operation of PMD? ☐ YES ☐ NO

Will client use a joystick to operate power seating? ☐ YES ☐ NO

Client will drive wheelchair with:

☐ Right hand ☐ Left hand ☐ Head array ☐ Chin

☐ Sip n Puff ☐ Mini joystick ☐ Micro switches

☐ Other: *(explain)* _____

_____

For Ultralight Justification

Client requires ultralight wheelchair for its adjustable axle plates and its additional lightness due to: *(check all that apply)*

- ☐ Limited upper extremity strength
- ☐ Limited upper extremity range of motion
- ☐ Upper extremity overuse syndrome
- ☐ Need for power assist system
- ☐ High activity level *(see client activities box below)*
- ☐ Other: *(explain)* _____

Patient Conditions Do any of the following conditions apply? *(check any that apply)*

- ☐ History of pressure sores
- ☐ Impaired trunk control
- ☐ Spasticity
- ☐ Orthopedic deformities of trunk and/or spine
- ☐ Inability to reposition to relieve pressure
- ☐ Contractures
- ☐ Poor judgment

STOP HERE for DME equipment (walkers, standers, gait trainers, beds, lifts & bathroom equipment).
STOP HERE for manual wheelchairs (K0001-K0005 with general-use seating) and basic PMDs (with general-use or captain seats) UNLESS one of the above "Patient Conditions" apply. If one of these conditions apply for ANY WHEELCHAIR ORDER continue completing Client Assessment.

CLIENT NAME: _____

Activities of Daily Living Assistance Needs

Activity:	Independent	Requires Assistance	Dependent
Toileting	☐	☐	☐
Feeding	☐	☐	☐
Dressing	☐	☐	☐
Grooming	☐	☐	☐
Bathing	☐	☐	☐

Client has a catheter?	☐ YES	☐ NO
Client requires assist with catheter?	☐ YES	☐ NO
Client is incontinent?	☐ YES	☐ NO
Client is tube fed?	☐ YES	☐ NO

Orthopedic Deformities *(check all that apply)*

Orthopedic:	Limited R.O.M. or Contractures:		
☐ Scoliosis	Hips	R ☐	L ☐
☐ Trunk rotation	Knees	R ☐	L ☐
☐ Kyphosis	Ankles	R ☐	L ☐
☐ Pelvic obliquity	Feet	R ☐	L ☐
☐ Pelvic rotation	Shoulders	R ☐	L ☐
☐ Posterior pelvic tilt	Elbows	R ☐	L ☐
☐ Anterior pelvic tilt	Wrists	R ☐	L ☐
☐ Leg length discrepancy	Hands	R ☐	L ☐
☐ Windswept lower extremities			

☐ Amputee (which limb or limbs and what level)_____

_____

Other *(check all that apply)*

☐ N/A
☐ Impaired sensation
☐ Impaired head control
☐ Ineffective weight shift
☐ Ventilator dependent
☐ Excessive extensor tone lower extremities
☐ Hypertonicity
☐ Hypotonicity
☐ Lower extremities edema
☐ If client currently has pressure sore(s), give location: _____

Client Activities *(check all that apply)*

☐ Work
☐ School
☐ Meal preparation
☐ Cares for children
☐ Housework
☐ Dr. and/or therapy appts.
☐ Church
☐ Shopping
☐ Volunteer activities
☐ Social activities

Equipment Use

Where will wheelchair be used? *(Check all that apply)*

☐ Work
☐ School
☐ Community
☐ Home
☐ Outdoors
☐ Other _____

Transportation

How will the wheelchair (wc) be transported?

☐ Van ☐ Car ☐ Other: *(explain)* _____

Vehicle for wheelchair transportation has the following:

☐ Lift ☐ Ramp ☐ Tie-Downs ☐ None

Client will drive while in wc?	☐ YES	☐ NO
Will wc fit in vehicle with client in it?	☐ YES	☐ NO
Will wc fit in vehicle for transportation?	☐ YES	☐ NO
Will client be transported by school bus?	☐ YES	☐ NO
Does client transfer self and wc in and out of vehicle independently?	☐ YES	☐ NO
Does client drive vehicle with modified hand controls?	☐ YES	☐ NO

Comments

_____

_____

_____

_____

_____

_____

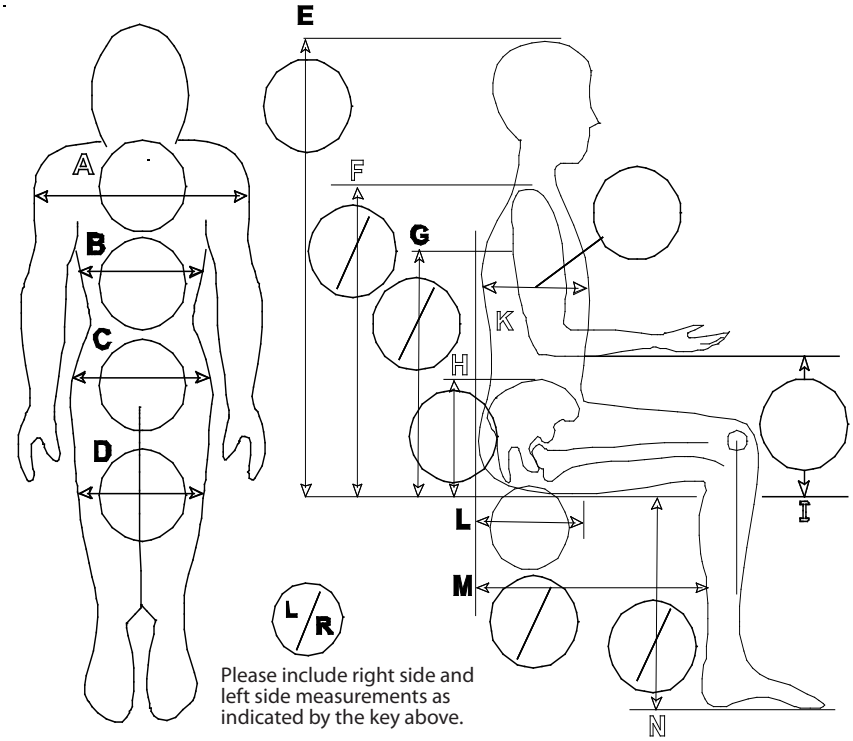
_____

Signature _____ **Date** _____

Signature _____ **Date** _____

Signature requirements may vary. Physician signature required for Managed Care; Therapist Signature required for Medicare; RTS Signature required for specific Managed Care & Medicaid plans.

CLIENT NAME: _____



Please include right side and left side measurements as indicated by the key above.

FOR INTERNAL USE ONLY

Height _____

Weight _____

Modifications Only ☐

Client Goals

PRIMARY GOAL: _____

Initial Score: _____ **Final Score:** _____

Scale of 1-5: 1=Poor 3=Acceptable 5=Excellent

Follow-up Needed? ☐ YES ☐ NO

Use the letter key to determine goal & the numerical code to rate the client's score.

A. Independent Mobility
B. Independent Sitting
C. Skin Integrity
D. Comfort
E. Posture
F. Transportation
G. Socialization
H. Other _____

Comments