Company/Facility Letterhead

Seating and Wheeled Mobility Pre-Appointment Questionnaire

Client's Name ____

1. **Does the person presently have an ambulatory aid?** ❒ No ❒ Yes; check all that apply

   ❒ Cane ❒ Walker ❒ Rolling walker ❒ Other ___________________________________

   Describe how the person walks: ____

   Does the person have history of falls? ❒ No ❒ Yes; frequency ___________________________

2. **Does the person presently have a wheelchair?** ❒ No ❒ Yes; check all that apply

   ❒ Stroller ❒ Transport chair ❒ Manual wheel chair ❒ Tilt-in-space ❒ Recliner

   ❒ Scooter ❒ Power wheelchair ❒ Other ____

   Manufacturer ____________________________ Model name ___________________________

   Equipment supplier ____

   Funding source __________________ Age _____ Condition ____________________________

   How many hrs/day does the person spend in the wheelchair? ___ hrs ❒ continuously ❒ on/off

3. **Why is new equipment needed?** ____

   ____

4. **What does the person like/not like about the current equipment** (describe) __________________

   ____

   ____

5. **Is the person comfortable in a seated position?** ❒ Yes ❒ No; describe __________________

   ____

6. **Has the person had any skin problems due to sitting or lying in bed?** ❒ No ❒ Yes

   Describe location and severity: ____

   ____

7. **How does the person perform a weight shift in sitting?**

   ❒ Independent ❒ Supervision ❒ Minimum assist ❒ Moderate assist ❒ Dependent

8. **What types of transfers are currently used?** (Check all that apply)

   ❒ Standing ❒ Squat pivot ❒ Pop over ❒ Transfer board ❒ Hoyer lift ❒ Other ___________

9. **How much assistance is needed with transfers?**

   ❒ Independent ❒ Minimal assist Moderate assist ❒ Maximal assist ❒ Two person assist

10. **List other equipment/furniture used during the day** (Check all that apply)

    ❒ Stander ❒ Sidelyer ❒Sofa ❒ Reclining chair ❒ Chair at table

    ❒ Other (describe) ____

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11. **Situations in which the system is being or will be used** (Check all that apply)

❒ Home ❒ Grass ❒ Carpet
❒ School ❒ Gravel ❒ Hardwood
❒ Work ❒ Pavement ❒ Brick
❒ Day Program ❒ Sidewalks ❒ Curbs
❒ Recreation ❒ Tile ❒ Ramps / inclines

12. **How will this system be transported?**
Private vehicle: ❒ 2-door sedan ❒ 4-door sedan ❒ SUV ❒ Adapted van
Public transport: ❒ School bus ❒ Handi-van ❒ Public bus ❒ Underground rail
Storage Place: ❒ Trunk ❒ Back seat ❒ Front seat ❒ Sits in wheelchair

13. **What other special equipment needs to be mounted to the wheelchair** (check all that apply)

❒ Oxygen tank ❒ Suction ❒ Ventilator ❒ Communication device ❒ Computer
❒ Crutch holder ❒ Walker ❒ I.V. pole ❒ Other ____

14. **Growth**: ❒ Normal growth for age ❒ Below normal growth for age

15. **Weight in last 6 months**: ❒ Stable ❒ Weight loss; _____lbs ❒ Weight gain; _____lbs

16. **Arm usage:** ❒ Full use both arms Use of one ❒ arm ❒ hand Unable to use ❒ arms ❒ hands

❒ Partial use of arms/hands (describe): ____

17. **Other devices used:** (check all that apply)

❒ Splint or braces ____________________________ ❒ Prosthetic device: ________________________
❒ Glasses ❒ Hearing aids ❒ Other ____

18. **Type of home:**

❒ Private home ❒ Apartment ❒ Independent living ❒ Assistive living ❒ Long-term care
❒ Mobile home ❒ Other _________________________________ ❒ One level ❒ Multi-level

Narrowest doorway _____ Entrance width ____ Wheelchair accessible rooms ❒ Yes ❒ No

19. **Does the approach/entrance to the home include**: (Check all that apply)

❒ Sidewalk ❒ Steps; number ____ height ____ width ____ ❒ Threshold; height: ____
❒ Ramp; length ____ width ____

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

❒ Toilet ❒ Bedside commode ❒ Commode chair ❒ Diapers ❒ Catheter
❒ Other: _________________________________

21. **Are there physical limitations on the part of the caregiver(s)?** ❒ No ❒ Yes (describe)_________

____

22. What therapy and support services is the person currently receiving (check all that apply):

❒ Speech/language therapy ❒ Physical therapy ❒ Occupational therapy
❒ Psychological/Counseling services ❒ Home health services ❒ Skilled nursing services
❒ Wound care services ❒ Pain clinic services ❒ Personal Care Assistance

Return form to: ____

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