

OCCUPATIONAL THERAPY
Wheelchair and Seating Assessment

DATE: _____ THERAPIST: _____
NAME: _____ PHONE: _____
ADDRESS: _____

CONTACT: _____ PHONE: _____
ADDRESS: _____

VENDOR: _____

DATE OF BIRTH: _____ HEALTH CARD #: _____
ADP #: _____ PREV.ADP APPL.: YES • NO •

DIAGNOSIS and MEDICAL HISTORY:

WEIGHT: _____ HEIGHT: _____

METHOD OF PROPULSION: _____

METHOD OF TRANSFER: _____

CURRENT SEATING SYSTEM / WHEELCHAIR:

FAMILY / CAREGIVER CONCERNS RE CURRENT ADVICE:

SKIN CONDITION: _____ SENSATION: _____

CONTINENT: YES • NO •

COGNITIVE STATUS: _____ BEHAVIOR PROB.: NO • YES _____

FUNCTIONAL / SOCIAL ACTIVITIES:

OUTINGS: YES • NO •

FAMILY OUTINGS: YES • NO •

SCHOOL: YES • NO •

WORK: YES • NO •

ENVIRONMENT: *accessible* YES • NO _____

Occupational Therapist

CLIENT: _____

PROB./ POTENTIALS	OBJECTIVES	PROPERTIES	PRODUCT	OUTCOME
PELVIS <i>Hip _____</i> <i>Thigh R _____</i> <i> L _____</i> <i>Post. Pelvic tilt</i> <i>Ant. Pelvic tilt</i> <i>Obliquity L R low</i> <i>Rotation L R for ward</i>		<i>W _____ x D _____</i> <i>STF : Front Rear</i> <i>Recline • tilt •</i> <i>extra cover</i>		
TRUNK <i>Seat to shoulder _____</i> <i>Seat to axilla _____</i> <i>Scoliosis</i> <i>Kyphosis</i> <i>Rib hump L R</i> <i>Lateral flexion L R</i> <i>Forward flexion</i>		<i>Back Height _____</i> <i>back angle</i> <i>chest strap</i>		
U.E <i>Seat to elbow _____</i> <i>Flexor tone L R</i> <i>Extensor tone L R</i> <i>Flaccid L R</i>		<i>full desk hgt. Adj.</i> <i>control side L R</i> <i>swing away</i> <i>tray ½ full padded</i>		
L.E. <i>Knee / heel L</i> <i> R</i> <i>Tight hams L R</i> <i>Flexor tone</i> <i>Extensor tone</i> <i>Foot length L R</i>		<i>60° 70° 90° tapered</i> <i>ankle huggers</i> <i>foot box</i> <i>padded</i> <i>angle adjustable</i>		
HEAD / NECK <i>Offset L R</i> <i>Low tone</i> <i>Hyper extension</i>		<i>headrest – sm med lg</i> <i>offset L R</i>		
FUNCTION		<i>Seat belt</i> <i>Tires/wheels</i> <i>Brake extensions</i> <i>Antitippers</i> <i>Clothing guards</i>		

Trial Equipment required:

Trial Completed:

Date of Completion:

Occupational Therapist:

Date ADP forms mailed: