Seating and Mobility Assessment

Section 1

General Information and Client Goals

A. General Information	
Client Name:	
Client ID #:	
D.O.B.:	
Address:	
Physician:	
Therapist(s):	
Source of referral:	
Reason for referral:	
Date of referral:	
Date of assessment:	
Funding source:	
Dealer of choice:	
Living Situation (type/ caregiver support/ contact):	
Diagnosis:	
Relevant medical history/ surgical interventions/ Prognosis/ Allergies:	
Assessment sections used:	
Additional assessments and dates:	
Client gives permission to share necessary information with dealer/ funder ❑.	

B. Client/ Caregiver Concerns and Goals for Seating	
1.	
2.	
3.	
4.	
5.	

Section 2

Functional Assessment – page 1/3

A. Weightbearing/ Transfers and Lifts			
Walking:	❑ Not at all Distance/ terrain/ aids used:	❑ Inside home	❑ In community
Transfers:	(Describe method/ equipment / assistance/ frequency/ optimal seat to floor height)		
Lifts:	(Describe method/ equipment / assistance/ frequency)		

B. Wheelchair Mobility			
❑ Manual:	❑ (L) arm propulsion ❑ (L) foot propulsion	❑ (R) arm propulsion ❑ (R) foot propulsion	❑ Dependent for mobility
❑ Stroller:			
❑ Power mobility: Drive method:	❑ Power wheelchair (eg. Control site; R or L handed)	❑ Scooter (eg. Style of control on tiller)	
Comments:	(eg. Terrain; distance; endurance)		

C. Self Care				
Method of eating: Comments/ risk factors:	❑ Independent	❑ Assisted	❑ Dependent	❑ Tube Feed
Bowel and bladder management:	❑ Continent		Incontinent of: ❑ Bladder	❑ Bowel
	❑ Indwelling catheter	❑ Condom Drainage	❑ Intermittent Catheterization	❑ Incontinence Products:
	Frequency/ Schedule:			
Other ADL/ IADL: Methods/ Aids / Assistance used:	(eg. Dressing/ housekeeping/ meal preparation/ banking/ collecting mail/ laundry)			

Relevant Implications

Section 2: Functional Assessment continued – page 2/3

D. Work/ School and Leisure	
School/ Work:	
Leisure activities/ interests:	

E. Perceptual and Cognitive Status	
Vision:	❑ Functional / glasses ❑ Impaired ❑ Blind ❑ L / R neglect ❑ L / R visual field loss Comments:
Hearing:	❑ Functional/ hearing aids: L / R ❑ Impaired Comments:
Functional cognitive ability: (eg. judgment/ insight/ attention/ concentration/ memory/ learning/ impulse control/ problem solving/ motor planning)	❑ No apparent cognitive difficulties. Cognitive Screen used: ❑ Y ❑ N Score: Name of screening tool:
Cognitive/ Perceptual testing:	Further cognitive/ perceptual testing necessary: ❑ Y ❑ N ❑ Tests completed: ❑ Tests to be completed: ❑ North Shore Health Region Power Mobility Assessment in the Community Tool ❑ VIHA Power Mobility Toolkit ❑ Other:
	Comments:

F. Communication			
Method/ Aids used:	❑ Verbal	❑ Non Verbal	❑ Augmentative Communication Device:
Ability to direct care:			

Section 2: Functional Assessment continued – page 3/3

G. Environment

1. Home Accessibility

Entrances:	(eg. Building/ suite)
Stairs/ Ramps:	(eg. # of stairs/ location/ landings/ angle and width of ramp)
Elevator:	(eg. size/ access/ controls)
Flooring:	(eg. Carpet/ laminate/ thresholds)
Table heights:	
Access to: (consider narrowest door, corners, turning radius, transfer heights, etc.)	Kitchen: Bedroom: Bathroom: Toilet: Other:
Charging area:	
Community accessibility:	(school/ work/ outdoor terrain/ sidewalks/ curb/ elevators, etc.)

2. Transport

Method of transport:	❑ Handidart ❑ Tie down required?	❑ Bus	❑ Taxi
	❑ Car: ❑ Car seat required?	❑ 2 Door ❑ Hatchback	❑ 4 Door ❑ SUV
	❑ Van: If driving self: ❑ Driving in w/c ❑ Transfer to seat	Overall client height in w/c: __________ Minimum clearance height:	
Method of loading:	❑ Manually assisted (who, where):		
	❑ Power lifts (specify location):		
	❑ Ramp:	❑ Other:	

Relevant Implications

Relevant Implications

Section 3.2

Physical Assessment Short Form– page 1/4

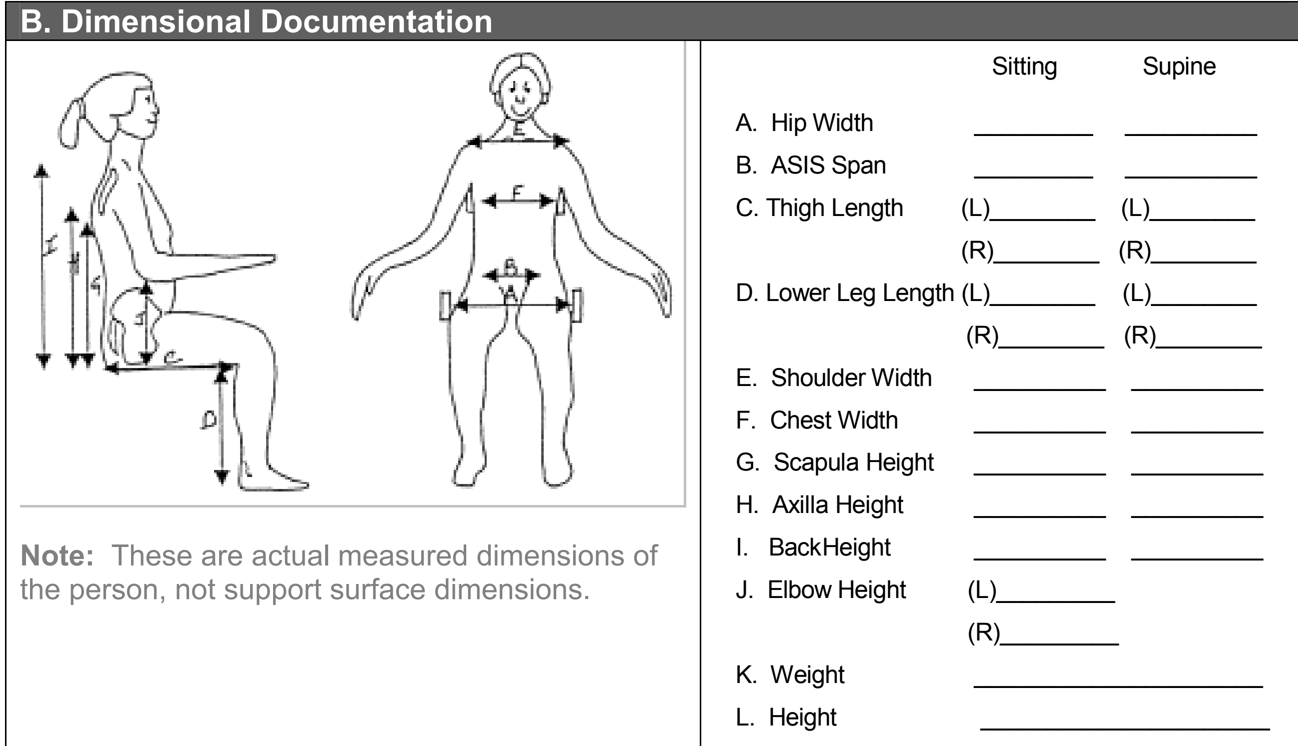
Key: **FA** = Full Active Correction **PA** = Partial Active Correction **NA** = No Active Correction
FP = Full Passive Correction **PP** = Partial Passive Correction **NP** = No Passive Correction
WNL = Within Normal Limits

Use Key to Describe "Correctable"

A. Physical Evaluation in Seating System/ Supine/ Sitting

		Position in current seating system	Supine Evaluation	Sitting Evaluation
Pelvis:	Tilt/ Lumbar Lordosis:			
	Rotation:			
	Obliquity:			
Hips:	Flex/Ext.:	R	R	R
		L	L	L
	Adduction / Abduction:	R	R	R
		L	L	L
	External Rot. / Internal Rot.:	R	R	R
		L	L	L
Knee/ Hamstrings:	When hip is at: R:___° L:___°		R	
			L	
Ankles / Feet:		R	R	R
		L	L	L
Trunk:	Rotation:			
	Kyphosis:			
	Scoliosis:	Leans to R ☐ L ☐		
Shoulders:	Alignment:	R	R	R
		L	L	L
Head/ Neck	Alignment:			

Section 3.2: Physical Assessment Short Form continued – page 2/4



B. Dimensional Documentation

Note: These are actual measured dimensions of the person, not support surface dimensions.

	Sitting	Supine
A. Hip Width	________	________
B. ASIS Span	________	________
C. Thigh Length	(L)________	(L)________
	(R)________	(R)________
D. Lower Leg Length	(L)________	(L)________
	(R)________	(R)________
E. Shoulder Width	________	________
F. Chest Width	________	________
G. Scapula Height	________	________
H. Axilla Height	________	________
I. BackHeight	________	________
J. Elbow Height	(L)________	
	(R)________	
K. Weight	________________	
L. Height	________________	

C. Skin Integrity

Weight Shift:	Independent: ❑ Y ❑ N ❑ power tilt / recline			
Sensation:	Impaired: ❑ N ❑ unable to assess ❑ Y – location:			
Edema:				
Skin Condition:	❑ Intact ❑ Affected area(s) ❑ History of ulcers			
	Affected sites:	**Healed (date):**	**Reddened (duration):**	**Open areas (stage of breakdown):**
	Ischial tuberosity R / L			
	Coccyx			
	Trochanter R / L			
	Spine			
	Other:			
	Possible cause(s) of skin ulcer:			
	Past solutions for affected areas:			
	Client aware of affected areas: ❑ Y ❑ N			
	Skin inspection routine: ❑ Y ❑ N Method:			

Section 3.2: Physical Assessment Short Form continued – page 3/4

C. Skin Integrity (continued)	
Sitting Tolerance:	Time spent in w/c without discomfort:
	Limiting factor(s):
	Tolerance: ❑ stable ❑ fluctuates:
	Assisted repositioning required throughout day: ❑ Y ❑ N Comments:
Measurement tools:	Braden Scale Score:
	Pressure Mapping:

D. General Physical Function	
Upper Extremity Function:	Dominance: ❒ L ❒ R General statement about range, strength, function:
Lower Extremity Function:	General statement about range, strength, function:
Respiration/ Cardio status:	❒ WNL ❒ SOBOE ❒ History of vascular disease ❒ History of COPD Oximeter reading with client in w/c (if available/ necessary):
Swallowing/ Reflux/ Digestion:	❒ WNL
Pain:	❒ No pain
Seizures:	❒ No history of seizures
Tone:	❒ WNL Describe tone in terms of: quality (hypertonic, hypotonic, flaccid or fluctuating); areas of the body most affected; the influence of movement; and postural control.

Section 3.2: Physical Assessment Short Form continued – page 4/4

D. General Physical Function (continued)	
Reflex Activity:	❒ WNL Reflex(es) present (i.e. ATNR, STNR, positive support reaction, grasp, startle, etc.)
	Influence of reflex on posture:
	Influence of reflex on movement:
Tremor/ Ataxia:	❒ WNL

Relevant Implications

Section 4

Current Mobility and Seating System – page 1/1

	Manual	Power
Make and Age of w/c:		
Supplier and funder:		
Frame type and size (width x depth x height):		
Seat base (type/ wxdxh) :		
Functional seat depth:	(measure from lower back support to front edge of seat cushion)	
Cushion (type/ wxdxh):		
Overall w/c or scooter width and length:		
Back type and accessories:		
Head support:		
Armrests:		
Leg Rests (type/ angle):		
Foot Plates (type/ size/ adjustability):		
Rear Wheel (type/ size/ position/ adjustability):		
Casters (type/ size/ position/ adjustability):		
Belt/ Harness:		
W/c tray/ basket:		
Drive Method: (type/ position/ mount)		
Other (mounts for assistive technology/ ventilators/ ADLs, oxygen/ wheel locks/ etc.):		
Fit and Function: (What does client love and what does the client hate about current wheelchair? What do you notice about the fit and function of wheelchair?)	Pros:	Pros:
	Cons:	Cons:

Section 5

Analysis and Recommendations– page 1/6

A. Seating/ Mobility Assessment Summary (Relevant Implications)	
Client goals/ concerns:	

Functional status and prognosis:	

Perceptual/ cognitive status:	

Environment status:	

Physical status:	

Section 5: Analysis and Recommendations continued – page 2/6

Include picture of client in current wheelchair, if camera available. Include in chart.

B. Targeted Outcomes

C. Plan for Equipment Trial

Use this checklist to begin analysis for equipment selection. Select the components based on the Client's functional and physical status as well as targeted outcomes.

1. Wheelchair Frame	Rationale:
New chair	
Modify fit of current chair, i.e. wider crossbraces, grow seat depth, change wheel sizes, etc.	
Rigid or folding	
Standard/ Tilt/ Recline	
Frame width and depth (growth potential)	
Seat to floor height	
Propulsion (wheel position adjustment/ camber/ one arm drive)	
Back posts (height/ angled or straight/ adjustable position/ adjustable angle/ stroller extension)	
Seat Angle	
Armrest type (desk or full length pads / sport style / flip-up / height or angle adjustable / cushion pad	
Footrest hanger (fixed / swing-away / angle / elevating / hanger mount)	
Footplate type (angle adjustable / size / material)	
Rear wheel (size / type of tire / pushrim / quick release axle)	
Caster (size / type of tire / fixed or angle adjustable / quick release)	
Other	

Section 5: Analysis and Recommendations continued – page 3/6

C. Plan for Equipment Trial (continued)	
2. Power	Rationale:
Power base (base separate from seating unit) or Power W/C (seat & base integrated)	
Drive wheel (rear / mid / front)	
Batteries & motor options	
Control/joystick site	
Alternate access	
Type/shape of joystick	
Electronic options	
Other	
3. Transportation	Rationale:
Rigid or folding	
Lift type and compatibility with wheelchair size	
Height of wheelchair for van transportation	
Tie-down	
Other	
4. Seat	Rationale (accommodate, prevent or correct):
Custom or commercial	
Functional seat depth	
Cushion size (width, depth, height, asymmetry)	
Cushion type (foam, gel, air, etc)	
Planar, contoured or custom molded	
Seat base (type/angle/drop)	
Ischial ledge	
Built-in abduction contouring	
Pressure relief	
Cover	
Finished seat to floor height	
Mounting hardware issues: i.e. interface between manual and power w/c	
Other	

Section 5: Analysis and Recommendations continued – page 4/6

C. Plan for Equipment Trial (continued)	
5. Back	Rationale (accommodate, prevent or correct):
Custom or commercial	
Planar, contoured or custom molded	
Height (consider need for shoulder straps)	
Sling or rigid	
Lumbar support / sacral block	
Kyphotic relief	
Lateral trunk support (depth of built-in contour / swing-away or rigid laterals) – how will laterals interface with back	
Mounting hardware issues	
Headrest mounting capabilities	
Other	
6. Pelvic Support	Rationale (accommodate, prevent or correct):
Pelvic/thigh laterals	
Seatbelt (seatbelt type, pelvic bar)	
Other	
7. Headrest	Rationale:
Pad type	
Type of mounting hardware (detachable / swing-away)	
Ease of adjustability	
Cover options	
Other	
8. Additional Positioning	Rationale (accommodate, prevent or correct):
Distal thigh pads	
Abduction pommel and type of hardware	
Anterior trunk/shoulder support (style of shoulder straps / chest panels /shoulder retractors etc.)	
Lower leg and foot stabilizers (shoe holders / foot straps / heel loops / calf strap / shin strap)	
Tray (mounting, pads, elbow blocks)	
Other	

Section 5: Analysis and Recommendations continued – page 5/6

C. Plan for Equipment Trial (continued)

9. W/C Accessories	Rationale:
Ventilator tray, O2 holder, cane/crutch holder, feeding pump/bag mount	
Brake Extension	
Grade aids	
Back pack	
Suspension	
Other	
10. Scooter	Rationale:
Tiller options	
3 or 4 wheel (wheel size)	
Suspension	
Controls (extensions, reverse, custom models)	
Seating options	
Other	

D. Summary of Equipment Trialed and Outcomes

Take picture of client in trial wheelchairs, if camera available. Include in chart.

Section 5: Analysis and Recommendations continued – page 6/6

E. Final Equipment Recommendation	
Please see equipment prescription/ quote dated:__________ Supplier: See attached order forms ❑	
Client aware and in agreement: ❑	
Frame:	
Power base:	
Transportation:	
Seat:	
Back:	
Pelvic support:	
Headrest:	
Additional positioning:	
Wheelchair Accessories:	
Scooter:	

Date: Signature: ____

Section 6

Outcomes – page 1/1

Final Seating/ Mobility Outcomes

Date: Signature: ______________________________