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.	