



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 <input type="checkbox"/> .	

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:	<input type="checkbox"/> Not at all <input type="checkbox"/> Inside home <input type="checkbox"/> In community Distance/ terrain/ aids used:
Transfers:	(Describe method/ equipment / assistance/ frequency/ optimal seat to floor height)
Lifts:	(Describe method/ equipment / assistance/ frequency)

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

C. Self Care	
Method of eating: Comments/ risk factors:	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent <input type="checkbox"/> Tube Feed
Bowel and bladder management:	<input type="checkbox"/> Continent Incontinent of: <input type="checkbox"/> Bladder <input type="checkbox"/> Bowel <input type="checkbox"/> Indwelling catheter <input type="checkbox"/> Condom Drainage <input type="checkbox"/> Intermittent Catheterization <input type="checkbox"/> 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:	<input type="checkbox"/> Functional / glasses <input type="checkbox"/> Impaired <input type="checkbox"/> Blind <input type="checkbox"/> L / R neglect <input type="checkbox"/> L / R visual field loss Comments:
Hearing:	<input type="checkbox"/> Functional/ hearing aids: L / R <input type="checkbox"/> Impaired Comments:
Functional cognitive ability: (eg. judgment/ insight/ attention/ concentration/ memory/ learning/ impulse control/ problem solving/ motor planning)	<input type="checkbox"/> No apparent cognitive difficulties. Cognitive Screen used: <input type="checkbox"/> Y <input type="checkbox"/> N Score: Name of screening tool:
Cognitive/ Perceptual testing:	Further cognitive/ perceptual testing necessary: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Tests completed: <input type="checkbox"/> Tests to be completed: <input type="checkbox"/> North Shore Health Region Power Mobility Assessment in the Community Tool <input type="checkbox"/> VIHA Power Mobility Toolkit <input type="checkbox"/> Other:
	Comments:

F. Communication			
Method/ Aids used:	<input type="checkbox"/> Verbal	<input type="checkbox"/> Non Verbal	<input type="checkbox"/> 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:	<input type="checkbox"/> Handidart	<input type="checkbox"/> Bus	<input type="checkbox"/> Taxi
	<input type="checkbox"/> Tie down required?		
	<input type="checkbox"/> Car:	<input type="checkbox"/> 2 Door	<input type="checkbox"/> 4 Door
	<input type="checkbox"/> Car seat required?	<input type="checkbox"/> Hatchback	<input type="checkbox"/> SUV
	<input type="checkbox"/> Van: If driving self: <input type="checkbox"/> Driving in w/c <input type="checkbox"/> Transfer to seat	Overall client height in w/c: _____	Minimum clearance height: _____
Method of loading:	<input type="checkbox"/> Manually assisted (who, where):		
	<input type="checkbox"/> Power lifts (specify location):		
	<input type="checkbox"/> Ramp:	<input type="checkbox"/> Other:	

Relevant Implications

Section 3.1

Physical Assessment Long Form– page 1/6

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

Use Key to Describe “Correctable”

A. Position in Current Seating System

Qualitatively describe presenting position of the client. Posture is described, rather than ranges available. Neutral refers to a position that appears comfortable.

Pelvis:	Tilt:	<input type="checkbox"/> Neutral	<input type="checkbox"/> Posterior Tilt	<input type="checkbox"/> Anterior Tilt				
	Rotation:	<input type="checkbox"/> Neutral	Rot. Forward	<input type="checkbox"/> L	<input type="checkbox"/> R			
	Obliquity:	<input type="checkbox"/> Neutral	ASIS Low	<input type="checkbox"/> L	<input type="checkbox"/> R			
Hips:	Flex/ Ext:	<input type="checkbox"/> Neutral	Flexed	<input type="checkbox"/> L	<input type="checkbox"/> R	Extended	<input type="checkbox"/> L	<input type="checkbox"/> R
	ABD/ Adduction:	<input type="checkbox"/> Neutral	Abducted	<input type="checkbox"/> L	<input type="checkbox"/> R	Adducted	<input type="checkbox"/> L	<input type="checkbox"/> R
	Rotation:	<input type="checkbox"/> Neutral	Int. Rotated	<input type="checkbox"/> L	<input type="checkbox"/> R	Ext. Rotated	<input type="checkbox"/> L	<input type="checkbox"/> R
	Windswept to:				<input type="checkbox"/> L	<input type="checkbox"/> R		
Knees:	<input type="checkbox"/> Neutral		Flexed	<input type="checkbox"/> L	<input type="checkbox"/> R	Extended	<input type="checkbox"/> L	<input type="checkbox"/> R
Feet/ Ankles:	<input type="checkbox"/> Neutral	Comment on position (dorsi/ plantar flexion, inversion/ eversion):						
Trunk:	<input type="checkbox"/> Neutral	<input type="checkbox"/> Increased Kyphosis:	Level: _____					
		<input type="checkbox"/> Leaning	<input type="checkbox"/> L	<input type="checkbox"/> R				
Shoulder:	Describe position (i.e. scapular position, tone, asymmetry, etc.):							
Head/ Neck:	Flex/Ext:	<input type="checkbox"/> Neutral	<input type="checkbox"/> Flexed	<input type="checkbox"/> Extended	<input type="checkbox"/> Chin Poke			
	Lateral Flexion:	<input type="checkbox"/> Neutral	<input type="checkbox"/> L	<input type="checkbox"/> R				
	Rotation:	<input type="checkbox"/> Neutral	<input type="checkbox"/> L	<input type="checkbox"/> R				
Comments								

B. Supine Evaluation

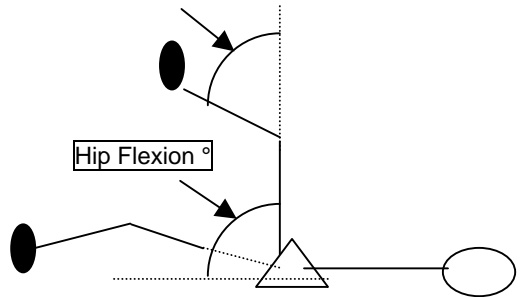
Pelvis:	Tilt (lumbar curve):	<input type="checkbox"/> WNL	<input type="checkbox"/> Posterior Tilt	<input type="checkbox"/> Anterior Tilt				
		Severity:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe			
		Correctable (key):						
Rotation:		<input type="checkbox"/> WNL	Rot. Forward	<input type="checkbox"/> L	<input type="checkbox"/> R			
		Severity:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe			
		Correctable (key):						
Obliquity:		<input type="checkbox"/> WNL	ASIS Low	<input type="checkbox"/> L	<input type="checkbox"/> R			
		Severity:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe			
		Correctable (key):						

Section 3.1: Physical Assessment Long Form continued – page 2/6

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Use Key to Describe "Correctable"

B. Supine Evaluation (continued)

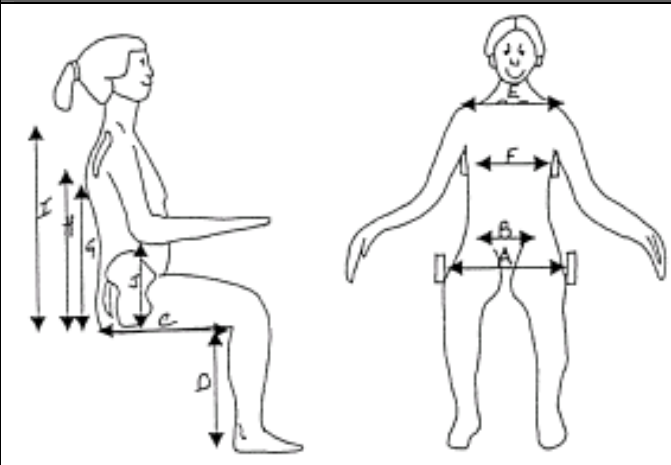
Range measured: <input type="checkbox"/> Comfort range <input type="checkbox"/> End Range		Below, describe if the range is fixed, correctable, increased or decreased from neutral:	
Hips:	Flexion:	°L °R	<input type="checkbox"/> WNL
	Abduction:	°L °R	<input type="checkbox"/> WNL
	Adduction:	°L °R	<input type="checkbox"/> WNL
	Int. Rotation:	°L °R	<input type="checkbox"/> WNL
	Ext. Rotation:	°L °R	<input type="checkbox"/> WNL
Knees:	Left: When hip is flexed to ____ degrees, knee lacks ____ degrees of full extension. Right: When hip is flexed to ____ degrees, knee lacks ____ degrees of full extension.		
Feet/ Ankles:	WNL <input type="checkbox"/> L <input type="checkbox"/> R Comment on limitations (dorsi/ plantar flexion, inversion/ eversion):	<div style="border: 1px solid black; padding: 5px; width: fit-content;">Amount of knee extension lacking (less than full ext.)</div> 	
Trunk:	Kyphosis:	<input type="checkbox"/> WNL Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Increased – vertebral level: ____ <input type="checkbox"/> Flattened– vertebral level: ____ Correctable:	
	Spinal Alignment:	<input type="checkbox"/> WNL	Describe presenting alignment:
	Rotation:	<input type="checkbox"/> WNL Correctable:	Rotation forward: <input type="checkbox"/> L <input type="checkbox"/> R
	Rib Hump:	<input type="checkbox"/> WNL <input type="checkbox"/> L rear <input type="checkbox"/> L front <input type="checkbox"/> R rear <input type="checkbox"/> R front Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Correctable:	
Shoulders:	Describe position (i.e. scapular position, tone, asymmetry, etc.):		
Head/ Neck:	Flex/Ext:	<input type="checkbox"/> WNL <input type="checkbox"/> Flexed <input type="checkbox"/> Extended <input type="checkbox"/> Chin Poke Correctable:	
	Lateral Flex:	<input type="checkbox"/> WNL <input type="checkbox"/> L <input type="checkbox"/> R	Correctable:
	Rotation:	<input type="checkbox"/> WNL <input type="checkbox"/> L <input type="checkbox"/> R	Correctable:

Section 3.1: Physical Assessment Long Form continued – page 3/6

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C. 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) _____ (R) _____	(L) _____ (R) _____
D. Lower Leg Length	(L) _____ (R) _____	(L) _____ (R) _____
E. Shoulder Width	_____	_____
F. Chest Width	_____	_____
G. Scapula Height	_____	_____
H. Axilla Height	_____	_____
I. Back Height	_____	_____
J. Elbow Height	(L) _____ (R) _____	_____
K. Weight	_____	_____
L. Height	_____	_____

D. Sitting Evaluation

Sitting Ability:	Good:	<input type="checkbox"/> moves in and out of position easily
	Fair:	<input type="checkbox"/> ability to move within base of support <input type="checkbox"/> moves out of base of support, is unable to move back
	Poor:	<input type="checkbox"/> maintains without movement <input type="checkbox"/> maintains with upper extremity support
	Dependent:	<input type="checkbox"/> unable to maintain a sitting position
	Not Present:	<input type="checkbox"/> unable to attain a sitting position
Pelvis:	Tilt (lumbar curve):	<input type="checkbox"/> WNL <input type="checkbox"/> Posterior Tilt <input type="checkbox"/> Anterior Tilt Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Correctable:
	Rotation:	<input type="checkbox"/> WNL Rot. Forward: <input type="checkbox"/> L <input type="checkbox"/> R Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Correctable:
	Obliquity:	<input type="checkbox"/> WNL ASIS Low: <input type="checkbox"/> L <input type="checkbox"/> R Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Correctable:

Section 3.1: Physical Assessment Long Form continued – page 4/6

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Use Key to Describe “Correctable”

D. Sitting Evaluation (continued)

Hips:	Flexion:	Describe comfortable hip range in sitting:				
	Abduction:	<input type="checkbox"/> WNL	<input type="checkbox"/> L	<input type="checkbox"/> R	Correctable:	
	Adduction:	<input type="checkbox"/> WNL	<input type="checkbox"/> L	<input type="checkbox"/> R	Correctable:	
	Int. Rotation:	<input type="checkbox"/> WNL	<input type="checkbox"/> L	<input type="checkbox"/> R	Correctable:	
	Ext. Rotation:	<input type="checkbox"/> WNL	<input type="checkbox"/> L	<input type="checkbox"/> R	Correctable:	
	Windswept to:	<input type="checkbox"/> WNL	<input type="checkbox"/> L	<input type="checkbox"/> R	Correctable:	
Knees:	Preferred degree of knee flexion:					
Feet/ Ankles:	WNL <input type="checkbox"/> L <input type="checkbox"/> R Comment on limitations (dorsi/ plantar flexion, inversion/ eversion):					
Trunk:	Kyphosis:	<input type="checkbox"/> WNL	Severity:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
		<input type="checkbox"/> Increased – vertebral level:_____		<input type="checkbox"/> Flattened– vertebral level:_____		Correctable:
	Spinal Alignment:	<input type="checkbox"/> WNL				
		Major Curve Convexity:	<input type="checkbox"/> L	<input type="checkbox"/> R	vertebral level:_____	
		Severity:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
	Minor Curve Convexity:	<input type="checkbox"/> L	<input type="checkbox"/> R	vertebral level:_____		
	Severity:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe		
	Correctable:					
	Rotation:	<input type="checkbox"/> WNL	Rotation forward:	<input type="checkbox"/> L	<input type="checkbox"/> R	Correctable:
	Rib Hump:	<input type="checkbox"/> WNL	<input type="checkbox"/> L rear	<input type="checkbox"/> L front	<input type="checkbox"/> R rear	<input type="checkbox"/> R front
	Severity:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe		Correctable:
	Correctable:					
Shoulders:	Describe position (i.e. scapular position, tone, asymmetry, etc.):					
Head/ Neck:	Flex/Ext:	<input type="checkbox"/> WNL	<input type="checkbox"/> Flexed	<input type="checkbox"/> Extended	<input type="checkbox"/> Chin Poke	Correctable:
	Lateral Flex:	<input type="checkbox"/> WNL	<input type="checkbox"/> L	<input type="checkbox"/> R	Correctable:	
	Rotation:	<input type="checkbox"/> WNL	<input type="checkbox"/> L	<input type="checkbox"/> R	Correctable:	

Section 3.1: Physical Assessment Long Form continued – page 5/6

E. Skin Integrity				
Sitting Tolerance:	Time spent in w/c without discomfort:			
	Limiting factor(s):			
	Tolerance: <input type="checkbox"/> stable <input type="checkbox"/> fluctuates:			
	Assisted repositioning required throughout day: <input type="checkbox"/> Y <input type="checkbox"/> N Comments:			
Weight Shift:	Independent: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> power tilt / recline			
Sensation:	Impaired: <input type="checkbox"/> N <input type="checkbox"/> unable to assess <input type="checkbox"/> Y - location:			
Edema:				
Skin Condition:	<input type="checkbox"/> Intact <input type="checkbox"/> Affected area(s) <input type="checkbox"/> 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: <input type="checkbox"/> Y <input type="checkbox"/> N			
	Skin inspection routine: <input type="checkbox"/> Y <input type="checkbox"/> N Method:			
Measurement tools:	Braden Scale Score:			
	Pressure Mapping:			

F. General Physical Function	
Upper Extremity Function:	Dominance: <input type="checkbox"/> L <input type="checkbox"/> R General statement about range, strength, function:
Lower Extremity Function:	General statement about range, strength, function:

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 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 6/6

E. Final Equipment Recommendation	
Please see equipment prescription/ quote dated: _____ Supplier: _____	
See attached order forms <input type="checkbox"/>	
Client aware and in agreement: <input type="checkbox"/>	
Frame:	
Power base:	
Transportation:	
Seat:	
Back:	
Pelvic support:	
Headrest:	
Additional positioning:	
Wheelchair Accessories:	
Scooter:	

Date: _____

Signature: _____

