

# Client Data Assessment Form for Wheelchair Seating

## Client Details:

Client Name:	Client Email Address:
Date of Birth:	Carer Name:
Gender:	Carer Contact Number:
Client Contact Number:	Assessment Date:

## Reason for Referral:

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## Medical History:

## Considerations for Outcome in Seating:

Diagnosis		
Condition	<input type="radio"/> Stable <input type="radio"/> Deteriorating	
Cognition and perception		
Medication		
Hearing	<input type="radio"/> Normal <input type="radio"/> Impaired <input type="radio"/> Deaf	
Vision	<input type="radio"/> Normal <input type="radio"/> Impaired <input type="radio"/> Blind	
Respiration	<input type="radio"/> Normal <input type="radio"/> Ventilator dependant <input type="radio"/> Oxygen dependant	
Sensation	<input type="radio"/> Intact <input type="radio"/> Impaired	
History of pressure injury (PI)?	<input type="radio"/> No <input type="radio"/> Yes _____	
Risk of PI related to seating?	<input type="radio"/> No <input type="radio"/> Yes _____	
Pressure relief	<input type="radio"/> Independant <input type="radio"/> Dependant <input type="radio"/> Assisted Method _____	
Pain history	Area of concern _____ Severity (1 = no pain, 5 = severe pain) _____	

## Postural Assessment:

Current wheelchair base	<input type="radio"/> Stroller <input type="radio"/> Manual <input type="radio"/> Tilt-in-space <input type="radio"/> Powerchair <input type="radio"/> None	
Impact of current seating in ADL's		
Postural needs and concerns		
Transfers	<input type="radio"/> Independent <input type="radio"/> Needs assistance <input type="radio"/> Dependent	
Client expectations from assessment		

## Draw any asymmetries that need to be addressed in seating:

FRONT VIEW (FRONTAL PLANE)	SIDE VIEW (SAGGITAL PLANE)	TOP VIEW (TRANSVERSE PLANE)

## Supine Assessment on the Plinth (MAT Evaluation)



Pelvis		Considerations for Outcome in Seating:
Anterior Tilt	<input type="radio"/> Reducible <input type="radio"/> Non-Reducible	
Posterior Tilt	<input type="radio"/> Reducible <input type="radio"/> Non-Reducible	
Rotation	<input type="radio"/> Left <input type="radio"/> Reducible <input type="radio"/> Right <input type="radio"/> Non-Reducible	
Obliquity (Lateral flexion)	<input type="radio"/> Left <input type="radio"/> Reducible <input type="radio"/> Right <input type="radio"/> Non-Reducible	
Hips	Left	Right
Dislocated/Subluxed		
Flexion		
Abduction		
Adduction		
Internal Rotation		
External Rotation		
Knees	Left	Right
Flexion		
Extension		
Feet	Left	Right
Dorsi-flexion		
Plantar flexion		
Upper Limb	Left	Right
Shoulder flexion		
Elbow flexion/extension		
Wrist/hand		
Skin Inspection		
Pelvis/buttocks		
Trunk		
Lower limbs		
Upper Limbs		
Muscle Tone		
<input type="radio"/> Normal		
<input type="radio"/> Increased	Body segments affected: _____	
<input type="radio"/> Decreased	Body segments affected: _____	
<input type="radio"/> Mixed	Describe: _____	

## Sitting Simulation on the Plinth



### Sitting Balance

- Hands-free sitter   
  Hands dependent sitter   
  Propped sitter

### Pelvis

- Neutral   
  Anterior pelvic tilt   
  Posterior pelvic tilt  
 Rotation -----  Left     Right  
 Obliquity -----  Left     Right

### Trunk

- Neutral   
  Scoliosis   
  Kyphosis   
  Lordosis  
 Other    Describe: \_\_\_\_\_

### Head and Neck

- Neutral   
  Extension   
  Flexion  
 Other    Describe: \_\_\_\_\_

### Considerations for Outcome in Seating:

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### Optimal position for sitting:

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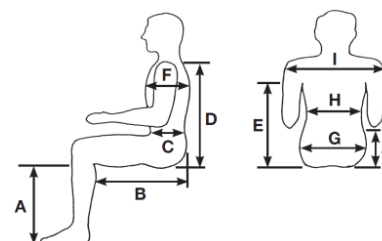
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### Seating Measurements:

	LEFT	RIGHT		LEFT	RIGHT
A Lower Leg Length			F Chest Depth		
B Thigh Depth			G Hip Width		
C Ischial Well Length			H Chest Width		
D Shoulder Height			I Shoulder Width		
E Axila Height			J Elbow Height		



Other Biomechanical Measurements:

### Wheelchair Measurements:

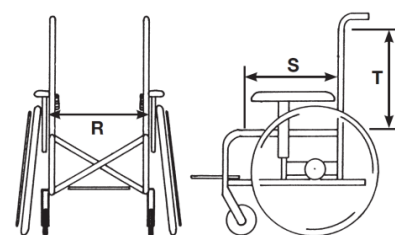
R Frame Width		S Seat Depth	
T Back Support Cane Height		Footplate Hanger Angle	

- Mobility Base Considered   
  Stroller   
  Manual   
  Tilt-in-space  
 Powerchair   
  None

Wheelchair Brand/Type

Wheelchair Cane Type

Wheelchair Notes



**Overall Notes to Translate The Previous Data Into Seating Components:**

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**Therapist Details**

Name	
Company	
Contact Number	
Email Address	

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