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:	

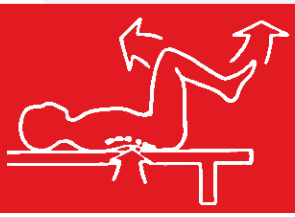
Reason for Referral:

Medical History:		Considerations for Outcome in Seating:
Diagnosis		
Condition	◯ Stable ◯ Deteriorating	
Cognition and perception		
Medication		
Hearing	◯ Normal ◯ Impaired ◯ Deaf	
Vision	◯ Normal ◯ Impaired ◯ Blind	
Respiration	◯ Normal ◯ Ventilator dependant ◯ Oxygen dependant	
Sensation	◯ Intact ◯ Impaired	
History of pressure injury (PI)?	◯ No ◯ Yes _____	
Risk of PI related to seating?	◯ No ◯ Yes _____	
Pressure relief	◯ Independant ◯ Dependant ◯ Assisted Method _____	
Pain history	Area of concern _____ Severity (1 = no pain, 5 = severe pain) _____	
Postural Assessment:		
Current wheelchair base	◯ Stroller ◯ Manual ◯ Tilt-in-space ◯ Powerchair ◯ None	
Impact of current seating in ADL's		
Postural needs and concerns		
Transfers	◯ Independent ◯ Needs assistance ◯ 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		◯ Reducible ◯ Non-Reducible	
Posterior Tilt		◯ Reducible ◯ Non-Reducible	
Rotation	◯ Left ◯ Right	◯ Reducible ◯ Non-Reducible	
Obliquity (Lateral flexion)	◯ Left ◯ Right	◯ Reducible ◯ 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			
◯ Normal			
◯ Increased	Body segments affected: _____		
◯ Decreased	Body segments affected: _____		
◯ 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

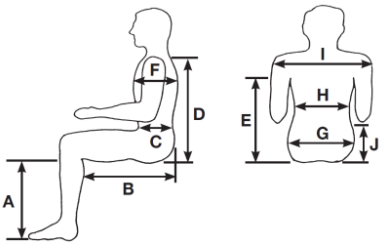
◯ Other Describe:_____

Considerations for Outcome in Seating:

Optimal position for sitting:

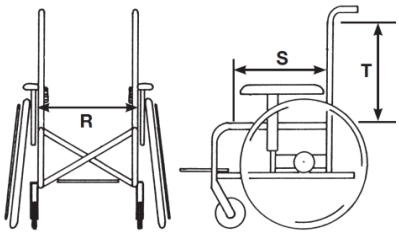
Seating Measurements:

	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:

Therapist Details	
Name	
Company	
Contact Number	
Email Address	

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