EDUCATION IN MOTION

WHERE THEORY MEETS PRACTICE

Seating & Mobility Evaluation

Patient Information:

Name:_____
Address: _____
_____
Phone:_____
Email: _____
Funding Source: _____

Date of Evaluation:_____
Sex: _____ Age: _____
Height: _____ Weight: _____
Primary Caregiver:_____
Caregiver Phone:_____
Referred By: _____

Physician: _____
Therapist:_____
Therapist:_____
Supplier: _____
Company: _____
Supplier Phone: _____

Reason for Referral:

Patient Goals:

Caregiver Goals:

Medical History:

Dx:

Other related Diagnoses:

Hx:

Recent/Planned Surgeries:

Cardio-Respiratory Status:
Impaired: ❑ Yes ❑ No

Medications:

Current Seating/Mobility:

Chair: _____ Age: ____ Serial Number: _____ W/C Cushion: _____ Age ____ W/C Back: _____ Age: ____
Reason for: ❑ Replacement ❑ Repair ❑ Update ❑ Comments: _____

Additional Equipment used on chair:

Replace with O2/Ventilator _____ Age: ____ Stander: _____ Age:____
Bath Equipment: _____ Age: ____ Augmentive Com Device:_____
Mounting:_____Comments: _____

Home Environment:

❑ House ❑ Apt ❑ Asst Living ❑ Long Term Care Facility (LTCF)/Nursing Home ❑ Alone ❑ w/ Family-Caregivers
Entrance; ❑ Level ❑ Ramp ❑ Lift ❑ Stairs
w/c Accessible Rooms: ❑ Yes ❑ No Narrowest Doorway to Acess: _____
Any Notable Critical Dimensions: _____ Comments: _____

Community Activities of Daily Living (ADL):

Transportation: ❑ Car ❑ Van ❑ Bus ❑ Adapted Van/independent driven ❑ Ambulance ❑ Other:_____

Driving Requirements: _____
Employment Requirements: _____
Educational Requirements: _____
Terrain Encountered: _____
Typical Distance: _____
Other: _____

Cognitive /Visual / Hearing Status:

Memory Skills:	❑ Intact	❑ Impaired	Comments _____
Problem Solving:	❑ Intact	❑ Impaired	Comments _____
Judgement	❑ Intact	❑ Impaired	Comments _____
Attn/Concentration:	❑ Intact	❑ Impaired	Comments _____
Vision:	❑ Intact	❑ Impaired	Comments _____
Hearing:	❑ Intact	❑ Impaired	Comments _____
Communication:	❑ Intact	❑ Impaired	Comments _____

Ambulation:

❑ Unable ❑ With Device
Distance:_____
Falls:_____
Other Safety Issues: _____

Seating & Mobility Evaluation *(Continued)*

Muscle Tone:

- ❑ Normal
- ❑ Low Tone Describe: _____
- ❑ High Tone Describe: _____
- ❑ Dystonic Describe: _____
- ❑ Abnormal Reflexes Describe: _____

Medical Management: _____

ADL Status:

	Indep	Assist	Unable	Comments:
Dressing/Bathing: Feeding:	❑	❑	❑	_____
Grooming/Hygiene:	❑	❑	❑	_____
Meal Prep:	❑	❑	❑	_____
Home Management:	❑	❑	❑	_____
Bladder/Bowel Management:	❑	❑	❑	_____
	❑ Continent		❑ Incontinent	_____

Wheelchair Management:

	Indep	Assist	Unable	N/A	Comments:
Bed ⟷ W/C Transfers	❑	❑	❑	❑	_____
W/C ⟷ Commode Transfers	❑	❑	❑	❑	_____
Manual W/C Propulsion	❑	❑	❑	❑	_____
Operate Power W/C Std. Joystick	❑	❑	❑	❑	_____
Operate Power W/C Alt. Controls	❑	❑	❑	❑	_____
Able to perform Weight Shifts	❑	❑	❑	❑	_____
Bed Confined without W/C	❑	❑			

Activity Level: _____

Additional Comments: _____

Sensation:

❑ Intact ❑ Impaired ❑ Absent Hx of Pressure Injuries ❑ Yes ❑ No Current Pressure Injuries ❑ Yes ❑ No ❑ Waterlow Score _____

Comments: _____

Mode of Weight Shift:

Mode of Weight Shift Method: ❑ Independent ❑ Dependent ❑ Assisted

Describe Effectiveness: _____

Describe Duration: _____

Describe Frequency: _____

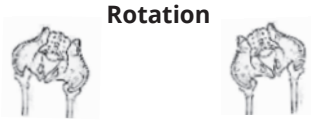
Cognition:

Judgement: _____

Attn / Concentration: _____

Vision: _____

Posture in Current Seating:

	Tilt	Obliquity	Rotation
PELVIS	 ❑ Posterior ❑ Anterior	 ❑ Left Low ❑ Right Low	 ❑ Left Forward ❑ Right Forward
	Anterior/Posterior	**Left Right**	**Rotation**
TRUNK	 ❑ Kyphosis ❑ Lordosis	 ❑ Left Scoliosis ❑ Right Sciliosis	 ❑ Left Forward ❑ Right Forward

Goals:

❑ Seating System ❑ Mobility Base ❑ Other: _____

Comments: _____

Supine Mat Evaluation

PELVIS
With Functional Limits (WFL)

Anterior/Posterior

❑ Neutral ❑ Posterior ❑ Anterior

❑ Non-reducible ❑ Reducible
❑ Partly Reducible ❑ Other

Obliquity

❑ WFL ❑ Left Low ❑ Right Low

❑ Non-reducible ❑ Reducible
❑ Partly Reducible ❑ Other

Rotation

❑ WFL ❑ Left Forward ❑ Right Forward

❑ Non-reducible ❑ Reducible
❑ Partly Reducible ❑ Other

COMMENTS

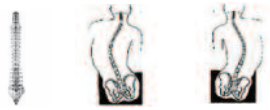
TRUNK

Anterior/Posterior

❑ WFL ❑ Thoracic Kyphosis ❑ Lumbar Lordosis

❑ Non-reducible ❑ Reducible
❑ Partly Reducible ❑ Other

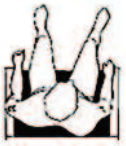
Left Right



❑ WFL ❑ Convex Left Scoliosis ❑ Convex Right Scoliosis

❑ Non-reducible ❑ Reducible
❑ Partly Reducible ❑ Other

Rotation



❑ Neutral
❑ Left Forward
❑ Right Forward

❑ Non-reducible ❑ Reducible
❑ Partly Reducible ❑ Other

HIPS

Position

❑ Neutral ❑ ABduct ❑ ADduct

❑ Non-reducible ❑ Subluxed
❑ Partly Reducible ❑ Dislocated
❑ Reducible

Windswept

❑ Neutral ❑ Right ❑ Left

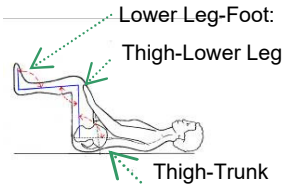
❑ Non-reducible ❑ Other
❑ Partly Reducible
❑ Reducible

Rotation

❑ Int Rot.: _____° ❑ _____°
❑ Ext Rot.: _____° ❑ _____°

Angles

	Range of Motion *Left*	*Right*
Trunk-Thigh Angle: "Hip flexion"		
Thigh-Low Leg Angle: "Knee Extention"		
Lower Leg-Foot Angle:		



KNEES & FEET

Foot Positioning

❑ WFL ❑ L ❑ R
❑ Dorsi-Flexed ❑ L ❑ R
❑ Plantar Flexed ❑ L ❑ R
❑ Inversion ❑ L ❑ R
❑ Eversion ❑ L ❑ R

COMMENTS

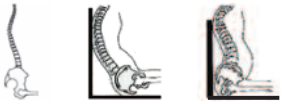
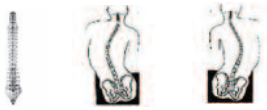
HEAD & NECK

❑ Functional
❑ Flexed ❑ Extended
❑ Rotated ❑ Lat Flexed
❑ Cervical Hyperextension

❑ Good Head Control
❑ Adequate Head Control
❑ Limited Head Control
❑ Absent Head Control

COMMENTS

Sitting Mat Evaluation

				COMMENTS
PELVIS With Functional Limits (WFL)	**Anterior/Posterior**  ❑ Neutral ❑ Posterior ❑ Anterior ❑ Non-reducible ❑ Reducible ❑ Partly Reducible ❑ Other	**Obliquity**  ❑ WFL ❑ Left Low ❑ Right Low ❑ Non-reducible ❑ Reducible ❑ Partly Reducible ❑ Other	**Rotation**  ❑ WFL ❑ Left Forward ❑ Right Forward ❑ Non-reducible ❑ Reducible ❑ Partly Reducible ❑ Other	
HIPS	**Position**  ❑ Neutral ❑ ABduct ❑ ADduct ❑ Non-reducible ❑ Subluxed ❑ Partly Reducible ❑ Dislocated ❑ Reducible	**Windswept**  ❑ Neutral ❑ Right ❑ Left ❑ Non-reducible ❑ Other ❑ Partly Reducible ❑ Reducible	**Range of Motion**  **Left** **Right** ❑ Redu: _____° ❑ _____° ❑ Ext: _____° ❑ _____° ❑ Int Rot.: _____° ❑ _____° ❑ Ext Rot.: _____° ❑ _____°	
TRUNK	**Anterior/Posterior**  ❑ WFL ❑ Thoracic Kyphosis ❑ Lumbar Lordosis ❑ Non-reducible ❑ Reducible ❑ Partly Reducible ❑ Other	**Left Right**  ❑ WFL ❑ Convex Left Scoliosis ❑ Convex Right Scoliosis ❑ Non-reducible ❑ Reducible ❑ Partly Reducible ❑ Other	**Rotation**  ❑ Neutral ❑ Left Forward ❑ Right Forward ❑ Non-reducible ❑ Reducible ❑ Partly Reducible ❑ Other	
UPPER EXTREMITY	**SHOULDERS** **Left** **Right** ❑ Functional ❑ Functional ❑ protracted ❑ protracted ❑ retracted ❑ retracted ❑ elevated ❑ elevated ❑ depressed ❑ depressed ❑ subluxed ❑ subluxed	**Significant R.O.M. Issues**	**COMMENTS**	
	ELBOWS **Left** **Right** ❑ Flexed ❑ Flexed ❑ Extended ❑ Extended	**Wrist Left** **Wrist Right** Description:		
HEAD & NECK	❑ Functional ❑ Flexed ❑ Extended ❑ Rotated ❑ Lat Flexed ❑ Cervical Hyperextension	❑ Good Head Control ❑ Adequate Head Control ❑ Limited Head Control ❑ Absent Head Control **R.O.M.**		
MOBILITY	**Balance** **Sitting Balance** **Standing Balance** ❑ WFL ❑ WFL ❑ Min Support ❑ Min Support ❑ Mod Support ❑ Mod Support ❑ Unable ❑ Unable	**Transfers** ❑ Independent ❑ Min Assist ❑ Max Assist ❑ Sliding Board ❑ Hoist Required		

Seating & Mobility Evaluation *(Continued)*

RECOMMENDATIONS:

Mobility Base & Components	Justification

Seating System & Components	Justification

Sunrise Physiotherapist / Occupational Therapist Signature: _____ Date:_____

Treating Therapist: I have read and concur with the above assessment. _____

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