Patricia Neal Rehabilitation Center
Wheelchair and Seating Questionairre

Patient Name: _____ Patient Age: _____

Name/Relationship of person completing this form: _____
Home phone:_____Work or Cell phone:_____

Medical History

Please list all your diagnoses and when they started_____
_____
Who referred you /patient to seating clinic?_____
Why are you referred to this clinic?_____
Physicians involved with your care?_____
Allergies:
Height_____ Weight_____ Has your weight been stable? *Yes* *No*

Do you have sensation on your bottom (normal feeling)? *Yes* *No*

Have you had or do you have any skin breakdown/redness on your skin? *Yes* *No*
If yes, please describe location, size and depth of sore _____
If healed, how long did it take to heal sore_____
When did the sore start?_____
Do you have problems with bladder control? *Yes* *No* Use a catheter? *Yes* *No*

Do you have discomfort? *Yes* *No*
If yes, where?_____
Rate current pain on 1-10 scale with 10 being worst. _____

Does the patient have respiratory difficulties? Y*es* *No* On Oxygen? *Yes* *No*

Is there a history of: Seizures *yes* *no*
Low blood pressure *yes* *no*

Recent hospitalizations / surgeries or planned surgeries? *Yes* *No*
If yes,please list:

Is the patient receiving therapy services?
please circle *Physical Therapy, Occupational Therapy, Speech Therapy*
Please list provider of these services and phone*:*_____

Home Environment
Do you live in a (please circle) *1-level house, 2-level house, apartment, mobile home, assisted living, long term care facility, group home*

Is the residence wheelchair accessible? *Yes* *No* If not, please list rooms not accessible: _____

Is the entrance accessible to a wheelchair? *Yes (ramp, level entrance)*
No (# of steps_____)

Transportation

How will/is the wheelchair transported? *Public transportation* *Private Vehicle*

If private vehicle, please list make and model of vehicle. Also list type of lift system and weight limit if known _____

Do you ride in the wheelchair in the vehicle? *Yes* *No*

If yes, list type of tie-down system used_____

Medical Equipment

Please list medical equipment used at home (list mobility equipment, bathroom equipment, respiratory, etc):

Functional Status

Do you have good safety awareness? *Yes* *No*

Are there behavioral concerns? *Yes* *No*

Do you have visual problems? *Yes* *No* If yes, please explain_____

Are you able to sit unsupported? *Yes* *No*

Are you able to walk without help from another person? *Yes* *No*

If yes, do you require an assistive device? *walker, cane, crutches, other*_____

Do you use leg braces? *Yes* *No*

How far do you walk? _____(feet)

How do you currently transfer (get up from chair or bed)?

Independently, with a little help, with a lot of help, others lift the patient, A patient lift is used.

What problems are you having with the current wheelchair?

_____

How many hours per day are you in the wheelchair? _____

Are you comfortable in the wheelchair? *Yes* *No* If no, why not_____

Are you able to perform a pressure relief (lifting bottom up in wheelchair to relieve pressure)? *Yes* *No*

Where do you spend most of time during the day?

*sofa bed recliner lift chair stander wheelchair other*_____