WALKING AND WHEELING
'we get kids moving!'

Wheelchair Evaluation Medical Form

Interview Details

Patient Name: _____ DOB: _____ Gender: _____

Caregiver(s) Name: _____

Primary Physician: _____ Primary Therapist: _____

Current Wheelchair: _____

Age of Wheelchair: _____

Medical History

Primary Diagnosis: _____

Onset of Primary: _____

Medical History _____

_____

_____

_____

Surgical History: _____
(Please include
date of surgery) _____

_____

_____

_____

_____

_____

Patient's Current
Height and Weight: _____

_____

_____

Visual Deficits: _____

Cardio Status: _____

Respiratory Status: _____

Home Environment

Home Environment: ☐ House ☐ Condo/Town Home ☐ Apartment ☐ Rented ☐ Owned
Lives with: _____
Steps into Home: ☐ No ☐ Yes, if yes how many _____
Storage of Wheelchair: ☐ Home ☐ Other_____

Community ADL

Transportation: ☐ Car ☐ Full Size Van ☐ Mini Van ☐ Adapted W/C Van ☐ Public Transport ☐ Truck
Make and Model:_____

ADL Status

For the following activities of daily living please circle the option that best describes how much help your child needs.

Getting Dressed:	Independent	Minimal Assistance	Moderate Assistance	Maximum Assistance	Dependent
Eating with Utensils:	Independent	Minimal Assistance	Moderate Assistance	Maximum Assistance	Dependent
Eating Finger Foods:	Independent	Minimal Assistance	Moderate Assistance	Maximum Assistance	Dependent
Bathing/Hygiene:	Independent	Minimal Assistance	Moderate Assistance	Maximum Assistance	Dependent
Meal Preparation:	Independent	Minimal Assistance	Moderate Assistance	Maximum Assistance	Dependent
Bowel Management:	Continent	Incontinent	Accidents		
Bladder Management:	Continent	Incontinent	Accidents		