WALKING AND WHEELING
'we get kids moving!'

Reset

WHEELCHAIR/ADAPTIVE STROLLER QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Patient Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Parents/Legal Guardians/Caregiver(s):	
Primary Care Doctor (PCP):	**Primary Therapist:** ☐**PT** ☐**OT**

MEDICAL HISTORY

Primary Diagnosis:	**Onset of Primary:**

Surgeries/Procedures ☐ Yes ☐ No		
Date:		Name of Surgeon or Medical Professional that performed Surgery or Procedure:

Medical History/Other Diagnoses ☐ Yes ☐ No	
Year:	

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Patient's Current Height:	Patient's Current Weight:
Any significant height changes or trends? ☐ yes ☐ no If yes, explain:	Any significant weight changes or trends? ☐ yes ☐ no If yes, explain:

Other Health Status	Visual Deficits:	☐ NO KNOWN VISUAL DEFICITS
	Hearing Loss:	☐ NO KNOWN HEARING LOSS
	Cardio Status:	☐ NO KNOWN CARDIO ISSUES
	Respiratory Status:	☐ NO KNOWN RESPIRATORY ISSUES
Orthotics (check all that apply)	☐ foot orthotics ☐ wrist/hand orthotics ☐ elbow orthotics ☐ knee orthotics ☐ TLSO (scoliosis brace) ☐ No orthotics	

HOME EVIRONMENT

Home Environment	☐ House				☐ Rent	☐ Own
	☐ Condo/Town Home				☐ Rent	☐ Own
	☐ Apartment				☐ Rent	☐ Own
	☐ Trailer Home				☐ Rent	☐ Own
	Family/Household Members:					
	Steps into home? ☐ Yes ☐ No # of steps:					
	Are you willing and able to carry your child's wheelchair into your home?				☐ Yes	☐ No
	Do you have a ramp into your home?				☐ Yes	☐ No
Transportation	☐ Car	☐ Full Size Van	☐ Mini Van	☐ Adapted Wheelchair Van	☐ School Bus/Public Transport	☐ Truck
	Make:		Model:		☐ Rent	☐ Own
Handedness	☐ Left Hand Preference ☐ Right Hand Preference ☐ Does Not Show Hand Preference					
Communication	Does your child use any assistive technology devices for communication?				☐ Yes	☐ No
	If yes, what kind?					
Skin Breakdown	Does your child have a history of skin breakdown?				☐ Yes	☐ No
	If yes, explain:					

ACTIVITIES OF DAILY LIVING (ADL) STATUS

(for the following activities of daily living, please indicate 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 *(potty trained)* ☐ Incontinent *(in diapers)* ☐ Accidents
Bladder Management	☐ Continent *(potty trained)* ☐ Incontinent *(in diapers)* ☐ Accidents

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WHEELCHAIR

Current Wheelchair and/or Adaptive Stroller	Do you currently own a wheelchair and/or adaptive stroller? *(if yes, please list them below)*		☐ Yes	☐ No
	Name of Current Wheelchair/Adaptive Stroller	Age	Serial Number	
	Storage of Wheelchair/Adaptive Stroller: ☐ Home ☐ Other:			

TRANSFER SKILLS

From Floor to Chair	☐ Independent ☐ Minimal Assistance ☐ Moderate Assistance ☐ Maximum Assistance ☐ Dependent
From Bed to Chair	☐ Independent ☐ Minimal Assistance ☐ Moderate Assistance ☐ Maximum Assistance ☐ Dependent
Standing Pivot	☐ Independent ☐ Minimal Assistance ☐ Moderate Assistance ☐ Maximum Assistance ☐ Dependent

MOBILITY/BALANCE

Sitting Balance	☐ Independent ☐ Minimal Assistance ☐ Moderate Assistance ☐ Maximum Assistance ☐ Dependent
Standing Balance	☐ Independent ☐ Minimal Assistance ☐ Moderate Assistance ☐ Maximum Assistance ☐ Dependent
Walking	☐ Independent ☐ Minimal Assistance ☐ Moderate Assistance ☐ Maximum Assistance ☐ Dependent

WHEELCHAIR/ADAPTIVE STROLLER NEEDS, GOALS, & DAILY USE

What activities will the wheelchair/adaptive stroller ***primarily*** be used for?
Are there any specific activities your family participates in that you would like us to consider when determining the appropriate wheelchair or adaptive stroller for your child?
Please note any other concerns that you feel are relevant to this evaluation:
Signature of person completing this form:

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