Seating Assessment Form

Client Name: _____ Date of Assessment: _____

Primary Diagnosis: _____ DOB: _____

Funding Body: _____ Weight: _____

Reason for Referral: _____

Mobility and Seating Related Goals:

Section 1: Medical Background

Cause: ☐ Injury ☐ Health Condition

Impairment: ☐ Physical ☐ Neurological ☐ Cognitive ☐ Psychosomatic ☐ Sensory

Condition: ☐ Stable ☐ Deteriorating ☐ Fluctuating

History/Onset

Medication: _____

Medical Precautions (i.e. hip subluxation, epilepsy): _____

Other Related Assessments (i.e. home mods assessment, functional capacity):

Pressure Injury History and Risk

History of Pressure Injury (PI): ☐ Yes ☐ No

Sensation: ☐ Intact ☐ Impaired ☐ Absent

Is there a current PI: ☐ Yes ☐ No

Stage: _____ Staged by: _____

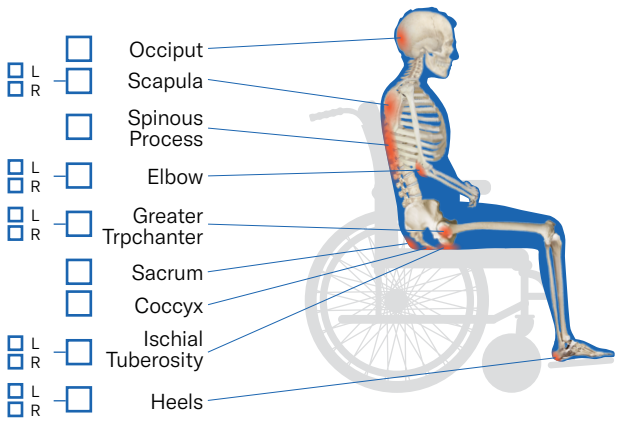
Seating Related: ☐ Yes ☐ No ☐ Unknown

Identified Risk Factors Related to Current Seating or Positioning: ☐ Yes ☐ No

Current Management Strategies and AT:

Requires Referral to Wound Care Specialist: ☐ Yes ☐ No

Location:



Other:

Seating Base (choose) **Power** **Manual**

Section 2: Current Mobility Base (Manual)

Manual Wheelchair Type

☐ Folding ☐ Rigid ☐ Tilt in Space

Manufacturer/Model:

Power Add-on: ☐ Front mounted ☐ Main wheel ☐ Rear mounted

Seat Dimensions _____ Front STF _____ Rear STF _____

Other: _____

Age of Current Wheelchair Base: _____ Condition: _____

Current Wheelchair Base: ☐ Meets Needs ☐ No Longer Meets Needs

Client Comments:

Propulsion: ☐ Independent Full-Time ☐ Independent Part-time

☐ Requires Assistance ☐ Dependent

☐ Foot Propel Left ☐ Foot Propel Right

Section 2: Current Mobility Base (Power)

Drive Wheel Configuration:

☐ Front Wheel Drive ☐ Mid Wheel Drive ☐ Rear Wheel Drive

Manufacturer/Model _____

Seat Width: _____ Seat Depth: _____ Access: _____

Seat Functions:

1. ☐ Tilt Degrees: _____
2. ☐ Recline ☐ Power ☐ Manual
3. ☐ Elevating Leg Rests ☐ Power ☐ Manual
4. ☐ Elevate
5. ☐ Anterior Tilt Degrees: _____
6. ☐ ActiveReach®
7. ☐ Stand

Age of Current Wheelchair Base: _____ Condition: _____

Current Wheelchair Base: ☐ Meet Needs ☐ No Longer Meets Needs

Client Comments:

Section 2: Current Seating and Mobility Base (Seating)

Cushion: _____ Cushion Size: _____ Other: _____

Cushion: ☐ Meets Needs ☐ Does Not Meet Needs

Backrest: _____ Backrest Size _____

If Applicable, Backrest Hardware: ☐ Removable ☐ Fixed ☐ Dynamic

Laterals: ☐ Yes ☐ No If Yes... ☐ Swing away ☐ Fixed ☐ Integrated

Backrest: ☐ Meets Needs ☐ Does Not Meet Needs

Other: _____

Additional Information:

Accessories

Hardrest: ☐ Yes ☐ No Additional Information: _____

Pelvic Support: ☐ Yes ☐ No If Yes... ☐ 2 Point ☐ 4 Point

Additional Mounting Information: _____

Anterior Trunk Support: ☐ Yes ☐ No Additional Information: _____

Other Accessories: ☐ Ankle Huggers ☐ Foot Cups ☐ Tray Other: _____

Additional Information:

Section 3: Functional Assessment

MAT Part One CURRENT SEATED POSITION

Pelvis

Saggital Plane ☐ Neutral ☐ Posterior Pelvic Tilt ☐ Anterior Pelvic Tilt

Additional Information: _____

Frontal Plane: ☐ Neutral ☐ Right Obliquity ☐ Left Obliquity

Additional Information: _____

Transverse Plane: ☐ Neutral ☐ Right Rotation ☐ Left Rotation

Additional Information: _____

Lower Extremities

Hip: ☐ Neutral ☐ Abducted ☐ R ☐ L ☐ Adducted ☐ R ☐ L

☐ Neutral ☐ Externally Rotated ☐ R ☐ L ☐ Internally Rotated ☐ R ☐ L

☐ Neutral ☐ Wind Sweeping ☐ R ☐ L

Feet: ☐ Neutral ☐ Eversion ☐ R ☐ L ☐ Inversion ☐ R ☐ L

☐ Neutral ☐ Plantarflexed ☐ R ☐ L ☐ Dorsiflexed ☐ R ☐ L

Additional Information: _____

Spine

Frontal Plane: ☐ Neutral ☐ Scoliosis Primary Curvature: ☐ Convex Right ☐ Convex Left

Additional Information: _____

Saggital Plane: ☐ Neutral ☐ Thoracic Kyphosis ☐ Lumbar Lordosis

Additional Information: _____

Cervical

Frontal Plane: ☐ Neutral ☐ Left Lateral Flexion ☐ Right Lateral Flexion

Saggital Plane: ☐ Neutral ☐ Flexed ☐ Extended ☐ Hyperextended

Transverse Plane: ☐ Neutral ☐ Left Rotation ☐ Right Rotation

Shoulder Complex

Left: ☐ Protracted ☐ Retracted ☐ NAD Additional Information:

Left Position: ☐ Low ☐ High ☐ NAD

Right: ☐ Protracted ☐ Retracted ☐ NAD

Right Position: ☐ Low ☐ High ☐ NAD _____

Function - Activities

Self-Care

Eating ☐ Independent ☐ Partial Assistance ☐ Dependent

Level of Assistance: _____

Grooming ☐ Independent ☐ Partial Assistance ☐ Dependent

Level of Assistance: _____

Bathing ☐ Independent ☐ Partial Assistance ☐ Dependent

Level of Assistance: _____

Dressing - Upper Body ☐ Independent ☐ Partial Assistance ☐ Dependent

Level of Assistance: _____

Dressing - Lower Body ☐ Independent ☐ Partial Assistance ☐ Dependent

Level of Assistance: _____

Toileting ☐ Independent ☐ Partial Assistance ☐ Dependent

Level of Assistance: _____

Transfers

Bed/Chair/Wheelchair ☐ Independent ☐ Partial Assistance ☐ Dependent

Level of Assistance _____

Toilet ☐ Independent ☐ Partial Assistance ☐ Dependent

Level of Assistance _____

Shower/Bath ☐ Independent ☐ Partial Assistance ☐ Dependent

Level of Assistance _____

Other:

_____

Home Environment (External and internal)

Household: ☐ Lives Alone ☐ Lives with Others

Support: ☐ Independent ☐ Family Support ☐ Carer Support

If Formal Support, Number of Hours/Package: _____

Home Accessibility: ☐ Accessible ☐ Non Accessible ☐ Requires Modification

Additional Information: _____

Community Environment

Environment: ☐ School ☐ Work ☐ Other: _____

Terrain: ☐ Uneven ☐ Grass/Soft Ground ☐ Gravel ☐ Other: _____

Gradient: ☐ Flat ☐ Hills ☐ Other: _____

Current Access in Environment: ☐ Independent ☐ Requires Assistance ☐ Dependent

Additional Information: _____

Transport

Transport: ☐ Modified Vehicle ☐ Vehicle ☐ Taxi ☐ Bus ☐ Train ☐ Other: _____

Vehicle: ☐ Passenger ☐ Driver

Transported: ☐ In Wheelchair ☐ In Vehicle Seat ☐ Other: _____

If Applicable: Wheelchair Restrain System: _____

Vehicle Model: _____

Requires Further Assessment: ☐ Yes ☐ No

Additional Information:

Supine MAT Evaluation

NOTE: Ensure starting point is users neutral, all ROM measured from max hip flex ROM.

Completed on Plinth: ☐ Yes ☐ No

Pelvis

Pelvic Tilt: ☐ NAD ☐ Anterior Pelvic Tilt ☐ Posterior Pelvic Tilt ☐ Reducible ☐ Non-Reducible

Pelvic Rotation: ☐ NAD ☐ R Rotation ☐ L Rotation ☐ Reducible ☐ Non-Reducible

Pelvic Obliquity: ☐ NAD ☐ R Obliquity ☐ L Obliquity ☐ Reducible ☐ Non-Reducible

Position	Right ROM	Left ROM	NAD	Comments
Hip Flexion	__° - __°	__° - __°		
Abduction	__° - __°	__° - __°		
Adduction	__° - __°	__° - __°		
Internal Rotation	__° - __°	__° - __°		
External Rotation	__° - __°	__° - __°		
Knee Extension	__° - __°	__° - __°		
Feet	__° - __°	__° - __°		

Tone and Primitive Reflexes

☐ Hypertonic ☐ Hypotonic ☐ Mixed (describe)

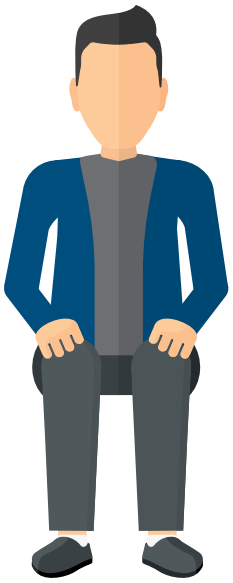
☐ Ataxia ☐ Athetosis

Identified Triggers or Inhibitors

Balance:

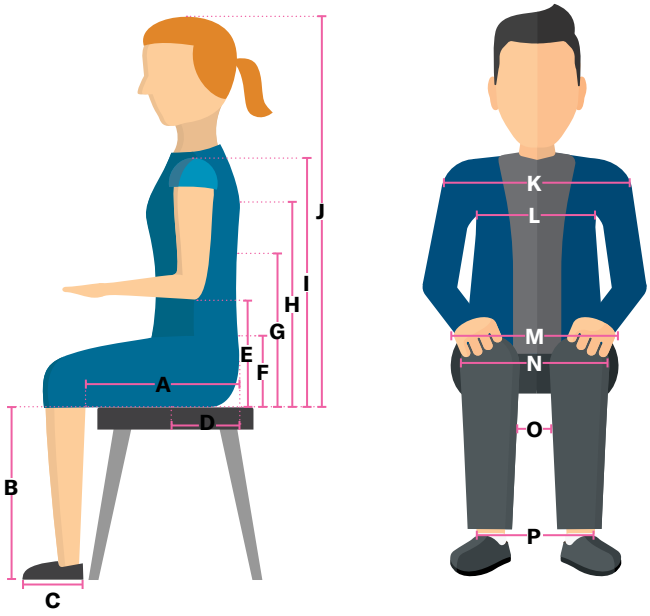
☐ Independent Sitting ☐ Sitting with Propping ☐ Unable to Sit without Support

Simulation



Clients Measurements in Proposed Position

L	R	
		A. Buttock Thigh Depth
		B. Lower Leg Length
		C. Foot Length
		D. Ischial Well Length
		E. Seat to Elbow
		F. PSIS
		G. Inferior Scapula
		H. Axilla
		I. Top of Shoulder
		J. Top of Head
		K. Shoulder Width
		L. Chest Width
		M. Hip Width
		N. External Knee Width
		O. Internal Knee Width
		P. External Ankle/Foot (at widest point)



Overall Width (assymetrical width for windswept legs or scoliotic posture)

Identified Barriers to Goals	Identified Postural/Mobility Issues	Potential Product Parameters

Potential Trial Equipment To Meet All Goals and Needs: