Seating Assessment Form

permobil

Client Name: ______________________
Date of Assessment: ______________________
Primary Diagnosis: ______________________
DOB: ______________________
Funding Body: ______________________
Weight: ______________________
Reason for Referral: ______________________
Mobility and Seating Related Goals:

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Section 1: Medical Background

Cause: O Injury O Health Condition

Impairment: O Physical O Neurological O Cognitive O Psychosomatic O Sensory

Condition: O Stable O Deteriorating O Fluctuating

History/Onset: ______________________

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Medication: ______________________

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

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

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Pressure Injury History and Risk

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

Sensation: O Intact O Impaired O Absent

Is there a current PI: O Yes O No

Stage: ______________ Staged by: ______________

Seating Related: O Yes O No O Unknown

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

Current Management Strategies and AT:

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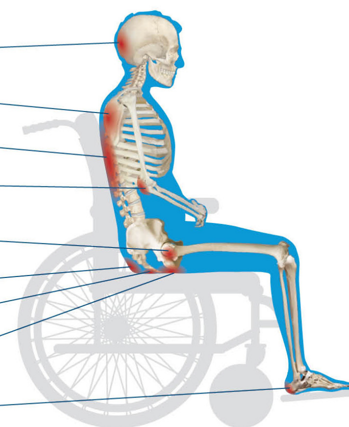
Requires Referral to Wound Care Specialist: O Yes O No

Location:



Other: ______________________

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Seating Base (choose): Power Manual

Section 2: Current Seating and Mobility Base (Manual)

Manual Wheelchair Type:

O Folding O Rigid O Tilt In Space

Manufacturer/Model: ______________________________

Power Add-on: O Front Attached O Push-Rim Activated O SmartDrive

Other: ______________________________

Age of Current Wheelchair Base: __________ Condition: ______________________________

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

Client Comments: ______________________________

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Propulsion: O Independent Full-Time O Independent Part-Time

O Requires Assistance O Dependent

Section 2: Current Seating and Mobility Base (Power)

Drive Wheel Configuration:

O Front Wheel Drive O Mid Wheel Drive O Rear Wheel Drive

Manufacturer/Model: ____________________

Seat Width: ____________ Seat Depth: ____________

Seat Functions:

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

Age of Current Wheelchair Base: ____________ Condition: ____________

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

Client Comments: ____________________

Section 2: Current Seating and Mobility Base (Seating)

Cushion:____________________ Cushion Size: _______________ Other: ____________________

Cushion: O Meets Needs O Does Not Meet Needs

Backrest: ____________________ Backrest Size: ____________________

If Applicable, Backrest Hardware: O Removable O Fixed O Integrated

Laterals: O Yes O No If Yes, O Swing Away O Fixed O Integrated

Backrest: O Meets Needs O Does Not Meet Needs

Other: ____

Additional Information: ____

Accessories

Headrest: O Yes O No Additional Information: ____________________

Postural Hipbelt: O Yes O No If yes, O 2 Point O 4 Point

Additional Mounting Information: ______________________________

Shoulder Harness: O Yes O No Additional Information: ____________________

Other Accessories: O Ankle Huggers O Foot Cups O Tray Other: ____________________

Additional Information: ____

Section 3: Functional Assessment

MAT Part One **CURRENT SEATED POSITION**

Pelvis

Saggital Plane: O Neutral O Posterior Pelvic Tilt O Anterior Pelvic Tilt

Additional Information: ______________________________

Frontal Plane: O Neutral O Right Obliquity O Left Obliquity

Additional Information: ______________________________

Transverse Plane: O Neutral O Right Rotation O Left Rotation

Additional Information: ______________________________

Lower Extremities

Hip:	O Neutral	O Abducted	O R O L	O Adducted	O R O L
	O Neutral	O Externally Rotated	O R O L	O Internally Rotated	O R O L
	O Neutral	O Wind Sweeping	O R O L		
Feet:	O Neutral	O Eversion	O R O L	O Inversion	O R O L
	O Neutral	O Plantarflexed	O R O L	O Dorsiflexed	O R O L

Additional Information: ______________________________

Spine

Frontal Plane: O Neutral O Scoliosis If Scoliosis, O Convex Right O Convex Left

Additional Information: ______________________________

Saggital Plane: O Neutral O Thoracic Kyphosis O Lumbar Lordosis

Additional Information: ______________________________

Cervical

Frontal Plane:	O Neutral	O Left Lateral Flexion	O Right Lateral Flexion	
Saggital Plane:	O Neutral	O Flexed	O Extended	O Hyperextended
Transverse Plane:	O Neutral	O Left Rotation	O Right Rotation	

Shoulder Complex

Left:	O Protracted	O Retracted	O NAD
Left Position:	O Low	O High	O NAD
Right:	O Protracted	O Retracted	O NAD
Right Position:	O Low	O High	O NAD

Additional Information: ______________________________

Section 3: Functional Assessment

Function - Activities

Self-Care

Eating	O Independent	O Partial Assistance	O Dependent
	Level of Assistance: ___		
Grooming	O Independent	O Partial Assistance	O Dependent
	Level of Assistance: ___		
Bathing	O Independent	O Partial Assistance	O Dependent
	Level of Assistance: ___		
Dressing - Upper Body	O Independent	O Partial Assistance	O Dependent
	Level of Assistance: ___		
Dressing - Lower Body	O Independent	O Partial Assistance	O Dependent
	Level of Assistance: ___		
Toileting	O Independent	O Partial Assistance	O Dependent
	Level of Assistance: ___		

Transfers

Bed/Chair/Wheelchair	O Independent	O Partial Assistance	O Dependent
	Level of Assistance: ___		
Toilet	O Independent	O Partial Assistance	O Dependent
	Level of Assistance: ___		
Shower/Bath	O Independent	O Partial Assistance	O Dependent
	Level of Assistance: ___		

Other: ___

___

___

Section 3: Functional Assessment

Home Environment (external and internal)

Household: O Lives Alone O Lives with Others

Support: O Independent O Family Support O Carer Support

If Formal Support, Number of Hours/Package: ____________________

Home Accessibility: O Accessible O Non Accessible O Requires Modification

Additional Information: ____________________

Community Environment

Environments: O School O Work O Other: ____________________

Terrain: O Uneven O Grass/Soft Ground O Gravel O Other: ____________________

Gradient: O Flat O Hills O Other: ____________________

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

Additional Information: ____________________

Transport

Transport: O Modified Vehicle O Vehicle O Taxi O Bus O Train O Other:

Vehicle: O Passenger O Driver

Transported: O In Wheelchair O In Vehicle Seat

If Applicable: Wheelchair Restrain System: ____________________

Vehicle Model: ____________________

Requires Further Assessment: O Yes O No

Additional Information: ____________________

Supine MAT Evaluation

NOTE: Be sure to position your client as symmetrical as possible before beginning the supine evaluation.

Completed on Plinth: O Yes O No

Pelvis

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

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

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

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

Tone and Primitive Reflexes

O Hypertonic O Hypotonic O Mixed (describe): ______________________

O Ataxia O Athetosis

Identified Triggers or Inhibitors: ______________________

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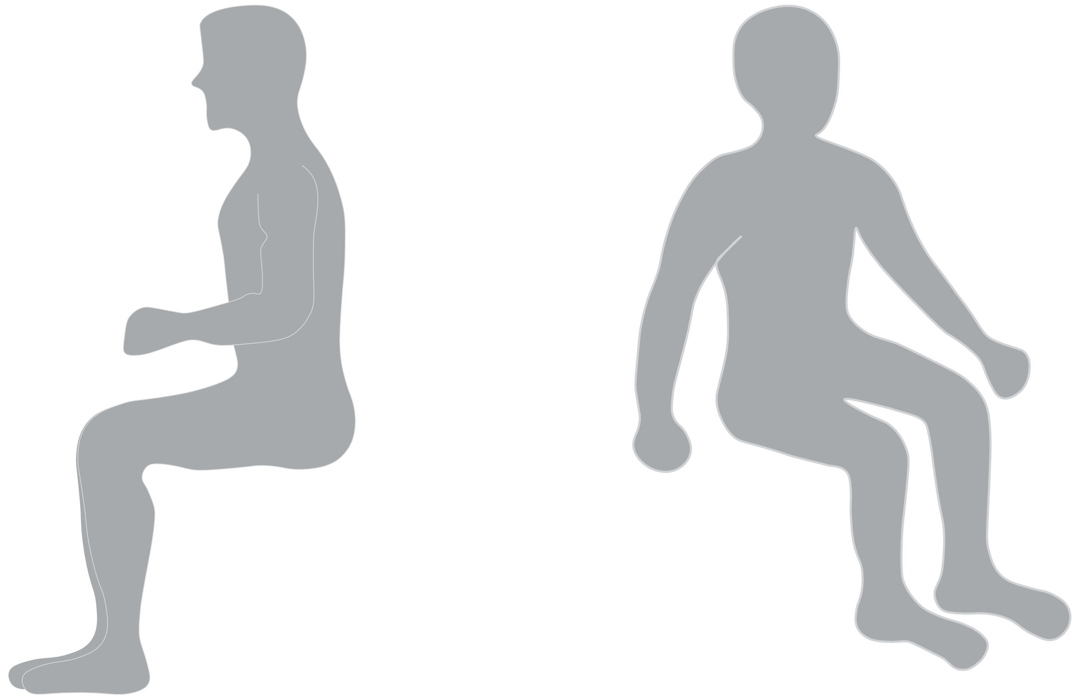
Balance:

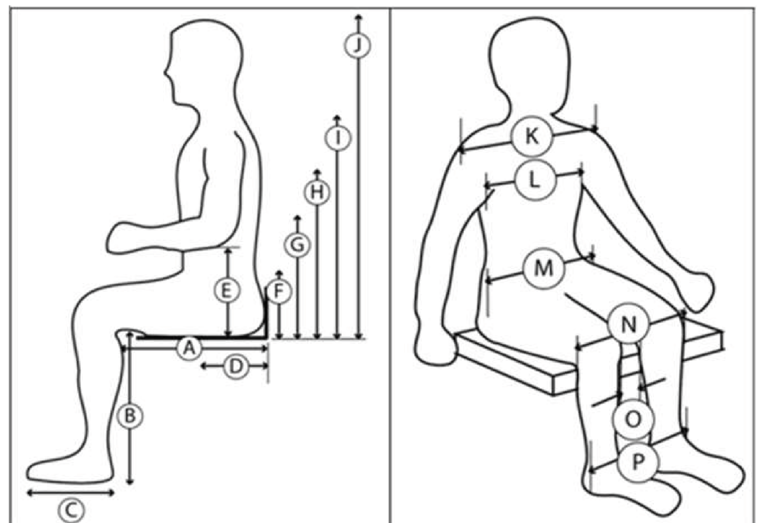
O Independent Sitting O Sitting with Propping O Unable to Sit Without Support

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: