r!kc
Rehabilitation Institute of KC
MEDICAL REHABILITATION | EMPLOYMENT PLACEMENT | DISABILITY SERVICES

Wheelchair/Seating Questionnaire

To assist us in providing you with a comprehensive assessment, please complete this form and bring it with you to your evaluation.

Name: _____ Date: _____

Disability: _____

Birthdate: ____/____/_____ Height:_____ Weight: _____

1. What are your goals for this wheelchair/seating evaluation?
   - ☐ New manual wheelchair
   - ☐ New wheelchair cushion
   - ☐ New power wheelchair
   - ☐ New wheelchair seating system
   - ☐ Other (if other please explain below)

2. When was the last time you had a wheelchair/seating evaluation? _____
   Did it result in you receiving new equipment? ☐Yes ☐No

3. Is there a particular wheelchair vendor you would prefer to work with? ☐Yes ☐No
   If so, who? Company _____
   Contact person _____
   Phone # _____

4. Are you currently working with another person or facility to get a wheelchair? ☐Yes ☐No
   If so, who? Company _____
   Contact person _____
   Phone # _____

5. Are you currently active in a therapy program? ☐Yes ☐No

6. Do you currently have skin breakdown? ☐Yes ☐No If yes, please state area of skin breakdown _____
   _____
   _____

7. Do you have a history of skin breakdown? ☐Yes ☐No If yes, please state when this occurred and area of breakdown _____
   _____
   _____

8. How many wheelchairs do you currently own? ____ Please describe (the type & approximate age)_____

_____

9. Do you use a power or a manual wheelchair? ☐ Manual ☐Power

10. If it's a power wheelchair, what drive method do you use?

- ☐ Right joy stick
- ☐ Left joy stick
- ☐ Chin control
- ☐ Head array
- ☐ Sip and Puff
- ☐ Other _____

11. If you have both a power and a manual wheelchair, which do you use primarily?
☐ Manual ☐Power

12. What wheelchair cushions do you own? _____

_____

13. Do you have any particular seating or positioning problems? If so, describe_____

_____

_____

14. Do you have any specialized seating items? ☐Yes ☐No If so, describe _____

_____

_____

15. How many hours a day are you up in your wheelchair? _____

16. What activities do you do from your wheelchair (i.e., work, school, etc.) _____

_____

17. Do you drive? ☐Yes ☐No Do you have an adapted vehicle? ☐Yes ☐No If so, please describe _____

_____

18. Do you use any Assistive Technology devices, such as a communication device or an environmental control unit? ☐Yes ☐No If so what? _____

_____

19. Do you need (or wish) to be able to access a computer from your wheelchair? _____

_____

_____